

Access to primary health care

An enquiry carried out on behalf of
the United Kingdom Health Departments

Jane Ritchie
Ann Jacoby
Margaret Bone

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OFFICE OF POPULATION CENSUSES AND SURVEYS
SOCIAL SURVEY DIVISION

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An enquiry carried out on behalf of
the United Kingdom Health Departments

Jane Ritchie
Ann Jacoby
Margaret Bone

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Notes to tables

Percentages may not add to 100 due to rounding. They have been rounded to the nearest whole number and those ending in .5 to the nearest even whole number.

. . denotes 0.5% or less.

– denotes no cases.

The actual number of cases is shown in parentheses () where the base is too small for the information to be given as a percentage.

In many tables the column totals do not add exactly to the table total (for example Table 4.1). This is due to missing information for a small number of cases which prevents their being allocated to any of the column sub-groups concerned.

PART 1 BACKGROUND AND DESIGN

1 Purpose and method of enquiry

1.1 Background to the survey

Primary health care is made available to members of the public through a wide range of services offered within the community. These services are provided either by practitioners, who enter into contracts with Family Practitioner Committees or Health Boards, or by other professional staff employed directly by the Health Authorities. General medical, dental, ophthalmic and pharmaceutical services are provided mainly by independent contractors operating from their own premises while the other primary health care services, such as chiropody, family planning and the domiciliary and preventive health services are more usually under the direct control of the Area Health Authorities and Boards.

The 1976 consultative document, *Priorities for Health and Social Services in England*¹, emphasised the importance of community health care in helping to relieve pressure on hospital and residential services and recommended that priority should be given to family doctor and other primary health care services. Similar documents were published for Scotland, Wales and Northern Ireland in 1976^{2, 3, 4}. The provision of these services is therefore of central concern to the four Health Departments of the UK and their use and availability require careful monitoring.

In recent years a number of changes have been taking place in the organisation of primary health care services, particularly in general medical practice. A major development has been the introduction of the primary health care team in which doctors, district nurses, health visitors and other professional staff work together to provide integrated care for patients. The need to provide adequate accommodation and facilities for this purpose has led to an acceleration in the building of health centres throughout the United Kingdom. The number of health centres in England rose from 25 in 1965 to 731 in March 1977. Another important trend has been the decline in the number of doctors practising single handed, together with a substantial growth in group practice. This has been accompanied by changes in practice administration aimed at rationalising workloads and available resources, such as the use of appointment systems. While all these changes have the aim of improving the efficiency and effectiveness of the services provided, there has been very little evaluation of how they affect the users of the service.

In view of the importance of the primary health care services, and the nature of the changes taking place within them, the responsible authorities decided that a comprehensive review of the accessibility of the services should be undertaken by means of a national survey among the general population. The present enquiry was therefore commissioned by the Department of Health and Social Security, the Welsh Office and the Scottish Home and Health Department. The subject matter of the survey was also of interest to the Royal Commission on the National Health Service whose terms of reference included Northern Ireland. The study was therefore extended to cover the whole of the United Kingdom, thus involving the Northern Ireland Department of Health and Social Services.

1.2 Aims and coverage of the survey

The broad objective of the survey was to examine patients' experience of, and views about, the accessibility of primary health care services. More specifically, the survey aimed:

- i) to provide information about patients' use of, and contacts with, the primary health care services;
- ii) to examine the extent to which features of the provision, organisation or delivery of the services affect access to the health care they provide;
- iii) to examine whether there are any groups within the population for whom difficulties of access exist.

The terms of reference called for specific attention to be paid to issues of accessibility for the elderly and for those living in areas classified as 'designated' where the ratio of patients to doctors is high*. It was also felt important that the views and experiences of those attending practices in health centres should be clearly identified.

The services covered by the enquiry are those provided by doctors, dentists, district nurses, health visitors,

* The classifications used by the Medical Practices Committee for England and Wales are dependent upon the average number of patients per general practitioner within a specifically delineated practice area, after allowing for the addition of one more doctor. A designated area is one where the average list size calculated in that way is 2500 or more. The purpose of the designated classification is to attract more doctors to an area by making initial practice allowances available to newcomers. Four classifications are used for England and Wales, but in Scotland an area is either designated or not designated, and there are minor differences in how such an area is classified. In Scotland, initial practice allowances are made available in districts approved by the Scottish Medical Practices Committee after consultation with Health Boards irrespective of whether the area is classified as 'designated' or not.

pharmacists, chiropodists, opticians and ophthalmic medical practitioners: in all cases the survey was concerned only with the health care provided within the community and outside hospital services. Certain primary services were omitted from the survey, in particular those available for family planning and ante and post natal care. The former were excluded because they have been the subject of intensive research in recent years⁵, the latter because an integral part of the service is hospital based and therefore outside the scope of this enquiry.

The central theme of the survey concerns access to the treatment provided by the primary health care services, but not the treatment itself. For all services, the main interest is in access to treatment provided through the National Health Service (NHS), although in some areas the use of private services has also been examined. The aspects of accessibility on which the survey focuses however do vary for the different services and are fully discussed in the relevant sections of the report.

1.3 Design of the sample

The sample for the survey was designed to be representative of adults aged 16 and over living in private households in the United Kingdom. By defining the target population in this way, two groups of potential users of the primary health care services were not covered by the survey. Children under 16 were excluded because it was felt that most of their contacts with the services would be made through their parents, and some account was taken of this in the design of the questionnaires. The other group excluded were individuals living in institutions (for example, colleges, hospitals, hostels, residential homes) on the basis that many institutions have special health care arrangements. This latter group, which presents complex sampling problems in general population samples, constitutes less than 3% of the adult population.

In order to cover the population of interest, a sample of individuals was selected from the Electoral Register and an additional procedure was used to select a sample of those aged 16 and 17 years. The Electoral Register sample was selected using a three stage design*. At the first stage, a sample of 164 Local Authority districts was selected. Four wards were then selected from within each of these districts and then approximately equal numbers of individuals from within each ward. The districts were stratified by standard economic region, density and the proportion living in designated areas before the primary stage selections took place.

The Marchant-Blyth method was used to select a sample of 16 and 17 year olds and other individuals not appearing on the Electoral Register. The same method was used to obtain a sample from addresses where the

named individuals selected from the Electoral Register had moved. The decision to sample individuals moving into an address, rather than following up the original named individuals to their new address, was made mainly on cost grounds, although it also has the advantage of simplifying the sampling procedure. This procedure meant that at some addresses there were no individuals subsequently selected for the survey. Full details of the Marchant-Blyth method are given in Appendix A.

The total sample selected for the survey was 5373 individuals. The sample was set at this order of size to ensure sufficient coverage of important sub-groups within the population, such as the elderly and those attending practices in health centres. The total sample covers the whole of the United Kingdom but includes a sample of double the *pro rata* size in Scotland. The increased sample in Scotland was requested by the Scottish Home and Health Department so that certain additional analyses which would not have been viable had the sample been of *pro rata* size, could be undertaken.

A full account of the sample design and procedure is given in Appendix A and sampling error is discussed in Appendix B.

1.4 The design of the survey

Information for the survey was collected through a personal interview at home with sampled individuals and a separate postal enquiry to Family Practitioner Committees and Health Boards about the general medical practices attended by respondents.

1.5 The personal interview

Because of the wide subject coverage of the survey, it was not considered feasible to ask every respondent about his contacts with all the primary health care services. To do so would have necessitated an extremely lengthy interview, particularly for heavy users of the services. As it was likely that many of this latter group would be elderly people, it was felt particularly important that the length of the interview should be restricted.

Two factors had to be taken into account in considering how the subject matter might be sub-divided. The first was the need for adequate coverage of certain minority groups for information relating to general medical practice—for example those attending practices in health centres and those living in designated areas. The second was the importance of including a sufficient number of patients aged 65 or over for particular services so that separate analysis for this group could be undertaken. It was therefore decided that everyone should be asked questions about general medical practitioners, district nurses and health visitors, that all informants aged 65 or over should be asked about the services provided by pharmacists, opticians, and chiropodists but that detailed questions about dental services should be restricted to patients aged 16–64. The

* The sampling method used in Northern Ireland differed slightly from the method used for Great Britain. Details of this are given in Appendix A.

decision to omit the full dental section for those aged 65 or over was made because their use of the other services was likely to be greater, rather than because dental services for the elderly are considered unimportant.

In order to facilitate the handling of this scheme, two separate questionnaires were designed. Both questionnaires contained an identical section on general medical practice, some limited questions about dental services and a short section covering classificatory data. The remaining part of each questionnaire was then confined to different services, with Questionnaire A covering pharmaceutical, ophthalmic and chiropody services and Questionnaire B covering more detailed information about dental services. (See Appendix C.)

Questionnaire A was asked of all informants aged 65 or over and one half of those aged 16-64. Questionnaire B was asked of the alternative half of the sample aged under 65. Thus the coverage of topics with the sampled respondents was as follows:

General medical practice (GPs, district nurses, health visitors)	} all respondents
Shortened dental section	
Classification data	
Pharmaceutical services	} all respondents aged 65 or over and one half of those aged 16-64
Ophthalmic services	
Chiropody services	
Dental services—full section	} one half of respondents aged 16-64

The interviews were carried out by OPCS field staff between May and July 1977. The average time taken to complete an interview was one and a quarter hours, although in cases where informants were very heavy users of the health services, the time taken was rather longer. Despite the relatively lengthy interviews, the survey was generally well received by respondents largely as a result of its subject matter.

Because of the subject matter and aims of the survey it was desirable to make some attempt to obtain information about sampled individuals who were too ill to give an interview. In these cases a shortened questionnaire was used to obtain factual information from someone responsible for the sampled person's care. Although 56 such interviews were obtained the information was not suitable for inclusion in the report. The individuals accounted for only 1% of all sampled individuals.

1.6 Response to the personal interview

The total sample selected to take part in an interview consisted of 5373 individuals in the United Kingdom. This included a sample of approximately 900 in

Scotland, which was double the *pro rata* size. From the individuals approached, 4733 full interviews and 56 proxy interviews were achieved, giving an overall response rate of 89%. Full details of the sample selected and response are shown in Table 1.1.

Table 1.1 Response to the personal interview

	Number
Original sample selected from Electoral Register	5632
Selected persons moved, died or living in institution	682
Additional sampled persons through Marchant-Blyth method	423
Total eligible persons	5373 = 100%
Achieved interviews—full	4733
—partial	2 = 89%
—proxy	56
Refusals	298 = 6%
Non-contacts (away all survey period; out at all calls; in hospital etc)	284 = 5%

1.7 Collection of practice information

One of the aims of the survey was to examine whether patients' experiences and views of access to general medical practitioners varied in relation to organisational aspects of the practices they attended. It was clear from the outset of the study that some of the information required for this analysis would not be known, or not known accurately, by the general public and would therefore need to be collected from another source. The people who took part in the survey were asked to give the name of their doctor and the address of the practice, and the information was then obtained from the appropriate Family Practitioner Committee or Health Board. Before the information was released however, every general practitioner concerned was notified and given the opportunity to register dissent if they did not wish the information to be made available for the purpose of the survey.

The information required about practices was as follows:

- number of general practitioners in practice;
- list size;
- number of patients aged 65 or over;
- whether practice in a Health Centre;
- whether practice has branch surgeries;
- Medical Practices Committee classification of the area.

The Family Practitioner Committees and Health Boards were asked to supply the details required by completing a short information sheet for every practice attended by the sampled informants. Before returning the sheets to OPCS, the name and address of the doctor concerned was detached, leaving only a reference number through which the practice information could be linked to the patients' data. No sheet was returned to OPCS in cases where doctors had given notification that they did not wish the information to be released.

1.8 Response to the collection of practice information

Fifty-five of the people interviewed were not registered with a general practitioner. A further 70 did not wish to

give the name and address of their doctor at the time of the interview, or gave insufficient information for the practice to be identified. This meant that there were 4667 individuals for whom practice information could be collected. Because of the clustering of the sample within wards, there were some cases where two or more people in the sample were registered at the same practice. Consequently, there were approximately 3000 practices for which information was required.

In response to a letter about the collection of practice information, just under 2% of the GPs approached

Table 1.2 Response to collection of practice information

	Number
Total persons interviewed (full, part or proxy)	4791
Informant not registered with GP	55
Total persons registered with GP	4736 = 100%
Informant not willing to give name and address of GP/gave insufficient information	70 = 1%
Informant's GP not willing for information to be released	101 = 2%
FPC/Health Board not able to supply information required	40 = 1%
Informants for whom practice information collected	4525 = 96%

wrote to say they did not wish the information to be released. There was also a small number of cases where FPCs or Health Boards were unable to provide the information for administrative reasons. Altogether, however, it was possible to obtain practice information for over 95% of informants who were registered with general practitioners, as shown in Table 1.2.

1.9 Plan of the report

The report is divided into three parts, the two main parts (II and III) dealing with each of the primary care services in turn. Before embarking on the main sections of the report, however, a description of the main variables used in the analysis of the data has been given as an aid to interpretation of the subsequent results.

References

- ¹ *Priorities for Health and Social Services in England*. A consultative document. HMSO. 1976.
- ² *The Health Services in Scotland—the way ahead*. HMSO. 1976.
- ³ *Proposed all Wales policies and priorities for the planning and provision of Health and Personal Social Services from 1976/77 to 1979/80*. A consultative document. Welsh Office. 1976.
- ⁴ *Strategy for the development of Health and Personal Social Services in Northern Ireland*. HMSO. 1976.
- ⁵ Margaret Bone. *The family planning services: changes and effects*. HMSO. 1978.

2 The classifications used in the analysis of the data

2.1 Introduction

Throughout the report certain demographic, social and regional variables have been used in the analysis and interpretation of the survey findings. The composition of these key variables and the distribution with respect to each is described below. Any classifications that relate specifically to individual subject areas (for example, practice characteristics, dental attendance pattern) are described in the relevant sections of the report.

Before showing any of the results of the survey the consequences of the sample design in terms of the presentation of the data need to be explained. As mentioned in the first chapter there were two ways in which certain groups of people selected in the random sample were treated slightly differently. Firstly, proportionally twice as many people were selected in Scotland as were selected in the other parts of the United Kingdom. This design decision was taken in order to increase the sample size in Scotland and therefore make it statistically viable to carry out some detailed and separate analyses for Scotland. Throughout the main body of the report the data for Scotland have been down-weighted to restore them to their true proportion for the United Kingdom. Secondly certain topics such as questions about opticians, pharmacists and chiropodists were asked of a disproportionately high number of elderly people, whereas detailed dental questions were only asked of a sub-sample of adults aged 16-64. These decisions were taken in order to accommodate all the subject matters that were of importance to the Health Departments but which, in total, amounted to too much to be included in one interview. Those topics which were of particular consequence for the elderly were thus overweighted so as to ensure a sufficient sample size for analysis while still managing to cover all the topic areas required. Thus some re-weighting of the data is necessary to restore the correct balance between the young and the old for those subject matters where a disproportionate number of the elderly were interviewed.

The tabulations in the report are shown with the sample bases down-weighted in order to restore them to represent the true proportions both regionally and for age. However, for those sections concerning opticians, pharmacists, and chiropodists, where the number of interviews was, in fact, substantially greater than the weighted base, the quality of the data is statistically more robust than the weighted sample base implies. In these chapters the numbers of interviews* have been shown in addition to the weighted base.

* These, of course, are still down-weighted for Scotland as described earlier in this chapter.

2.2 Demographic characteristics of the sample interviewed

Age and sex

Age and sex have inevitably been important discriminants for the subject matter of the inquiry and the age groups used in the course of the inquiry are shown in Table 2.1. For this first analysis, involving age

Table 2.1 Distribution of samples, by age and sex

	Total sample (16 and over)	Sample A§ (16 and over)	Sample B* (16-64 only)
Age	%	%	%
16-24	15	15	19
25-34	18	18	23
35-44	16	16	19
45-54	17	17	20
55-64	15	15	19
65-74	13	13	—
75 or over	6	6	—
Total	100	100	100
Sex			
Male	47	48	46
Female	53	52	54
Total	100	100	100
Weighted base	4343	2169	1769

	Male	Female	Male	Female	Male	Female
Age	%	%	%	%	%	%
16-24	16	14	16	14	20	18
25-34	20	17	20	17	24	22
35-44	16	16	15	16	19	19
45-54	16	17	17	16	18	22
55-64	15	15	15	16	19	19
65-74	12	13	12	13	—	—
75 and over	5	8	5	8	—	—
Total	100	100	100	100	100	100
Weighted base	2020	2323	1034	1130	817	952

§ In addition to the questions asked of everyone this sample was asked about opticians, pharmacists and chiropodists.

* In addition to the questions asked of everyone this sample was asked detailed questions about dental services.

and sex, we have presented the distributions for all three main groups that are analysed in the report, that is:

- The whole sample, who were all asked about general medical practitioners, health visitors and district nurses, basic questions on dentistry and some classification information.
- Sample A, which included all the elderly from the whole sample and one in two of the adults aged 16-64. In addition to the questions that went to everyone, this group and this group only were asked about opticians, pharmacists and chiropodists.
- Sample B, which was made up of the remaining half of adults aged 16-64 who were asked more detailed questions about dentistry.

Presenting the age and sex distribution for all three main groups of the sample illustrates that the distribution varies very slightly and the base numbers are of course different depending on which group is involved. It needs to be remembered that results based on sample B refer only to people aged 16-64. For the other demographic, social and regional characteristics the presentation has been confined to the total sample.

A comparison is made in Appendix A of the age and sex distribution of the sample compared with the general population. This shows that the sample is very slightly deficient amongst those under 25 for both men and women. Although this could be accounted for by sampling error, it is possible that the additional sampling procedure used may have affected the numbers obtained. This is discussed in more detail in Appendix A.

Social Class

The Registrar General's classification of occupations was used to define the informant's social class, using the occupation of the head of the household. In 4% of cases it was not possible to assign the informant to a social class group either because we had insufficient information or because the current head of household had never worked.

Table 2.2 Distribution of Social Class

Social class	Total Sample (16 and over)
	%
I Professional	6
II Managerial and technical	23
III Skilled occupations—non-manual	10
IV Skilled occupations—manual	34
V Semi-skilled occupations	16
U Unskilled occupations	6
Unable to classify/never worked	4
Total	100
Weighted base	4343

Family and household composition

It is often useful to know the kinds of family and household circumstances that affect people, especially in matters such as health and accessibility to services. One particularly relevant factor is whether the person interviewed has any children, particularly of a young age living at home, since this may well affect the nature of contacts with the health services. We have also distinguished between single-person households and those of two or more since a substantial proportion of the elderly live alone and this was of particular interest in relation to domiciliary services. It must be borne in mind when considering household composition that this survey is based on a sample of individuals and not a sample of households. The results thus show the proportion of individuals who live in single-person households, that is 10%, whereas if one is concerned with households then something like 21% of all households are single-person households¹.

Since both family and household composition are

closely related to age and sex, the relationships between all these variables have been shown. These relationships need to be kept in mind in the later more detailed analysis of the survey results.

Mobility

As the central theme of the survey concerned accessibility, it was important that we should identify individuals whose mobility was restricted in some way. In a small number of cases it became evident during the interview that the informant was permanently housebound and this information was recorded. All other informants, irrespective of their age, were asked if they had any difficulty getting out and about on their own, and if so, whether they were confined to their homes or not. The information provided showed that 1% of the sample were housebound and a further 5% had some difficulties getting out of the house alone. Because of the small numbers involved it has not been possible to identify the housebound separately in the later analysis but in some cases we have been able to differentiate between those with very restricted mobility and those who could get out alone if necessary.

There was understandably a close association between age and mobility. Over one fifth of those aged 65 or over had some difficulties getting out alone* compared with only 1% of those under 45. However the very small number of people under 65 with restricted mobility makes it difficult to draw any conclusions about the use and accessibility of the health services for this group.

2.3 Regional and area characteristics

Region and country

Throughout the report Regional Health Authorities have been used as a base for examining any geographical variation in the use and accessibility of health services. Because of the relatively small size of the sample in some RHAs we have, for most analyses, used a broad regional grouping within England but with separate presentations for each of the four countries (see Table 2.5). Although it was felt important to present information for each of the countries individually, it should be noted that the sample sizes in Wales, and, particularly, Northern Ireland are very small. The data presented for Wales and Northern Ireland are therefore subject to greater margins of error than for the other two countries and this also restricts the amount of secondary analysis which can be undertaken. (See Appendix B for sampling errors.)

The age, sex and social class distributions of the sample for each region and country are shown in Table 2.6. It can be seen that there are slight variations in the age social class structure of different areas of the country which need to be borne in mind in regional and country analysis.

* In the *Elderly at home* (HMSO 1978) Audrey Hunt found that, including housebound, 24% of persons aged 65 and over had some difficulties in going out alone (this survey covered England only).

Table 2.3 Family and household composition by age

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Males								
Informant's children:								
one or more under 5 yrs								
none 5-15 yrs	8	25	6	1	—	—	—	7
one or more under 5 yrs	1	20	13	2	—	—	—	6
and one or more 5-15 yrs								
one or more 5-15 yrs								
none under 5 yrs	91	13	59	35	7	—	—	19
no children under 16 yrs		42	22	62	93	100	100	68
Total	100	100	100	100	100	100	100	100
Household type:								
single person household	5	6	2	6	11	10	27	7
not	95	94	98	94	89	90	73	93
Total	100	100	100	100	100	100	100	100
Weighted base	332	396	318	325	311	242	93	2020*
Females								
Informant's children:								
one or more under 5 yrs								
none 5-15 yrs	15	24	2	..	—	—	—	7
one or more under 5 yrs	2	24	10	..	—	—	—	6
and one or more 5-15 yrs								
one or more 5-15 yrs	1	25	66	31	4	—	—	21
none under 5 yrs	82	27	22	69	96	100	100	66
no children under 16 yrs								
Total	100	100	100	100	100	100	100	100
Household type:								
single person household	3	4	2	5	16	37	51	13
not	97	96	98	95	84	63	49	87
Total	100	100	100	100	100	100	100	100
Weighted base	326	398	368	397	356	300	175	2323*
Persons								
Informant's children:								
one or more under 5 yrs								
none 5-15 yrs	11	25	4	..	—	—	—	7
one or more under 5 yrs	1	22	12	1	—	—	—	6
and one or more 5-15 yrs								
one or more 5-15 yrs	1	19	63	33	5	—	—	20
none under 5 yrs	87	34	21	66	95	100	100	67
no children under 16 yrs								
Total	100	100	100	100	100	100	100	100
Household type:								
single person household	4	5	2	5	14	25	43	10
not	96	95	98	95	86	75	57	90
Total	100	100	100	100	100	100	100	100
Weighted base	658	794	686	722	667	542	268	4343*

* Age was not given by 3 males and 3 females. These individuals are included in the total column.

Table 2.4 Distribution of mobility by age

Mobility	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Housebound	—	—	..	1	1	3	15	1
Restricted Mobility—								
can get out only if								
accompanied	..	..	..	1	1	3	10	2
Restricted Mobility—								
but can get out alone	1	1	1	1	5	9	15	3
Mobile	99	99	98	97	93	86	60	94
Total	100	100	100	100	100	100	100	100
Weighted base	658	794	686	722	667	542	268	4343

Table 2.5 Distribution by Regional Health Authorities

		Total Sample 16 and over
	%	
North	Northern	6
	Yorkshire	5
	Mersey	5
	Northwest	8
Midlands	West Midlands	12
	Trent	7
	East Anglia	2
South East	N W Thames	6
	N E Thames	4
	S E Thames	8
	S W Thames	6
South West	Southwest	6
	Oxford	3
	Wessex	4
England		84
Wales		5
Scotland		9
Northern Ireland		3
Total		100
Weighted base		4343

Rural areas

It was clearly important for the survey that we should identify informants living in rural areas since issues of accessibility were likely to be quite different from those in non-rural areas. It will be known, however, that since the local government reorganisation in 1974, there has been no readily available description of urban and rural districts and it was therefore necessary to compile some classification for the purpose of the survey. To do this it was necessary to find criteria which could be systematically applied to the several hundred wards from which the sample was drawn. After some investigation it was clear that no one indicator could reliably distinguish rural areas and the classification

used for the survey was based on three different sources of information. These were:

- ward density—electors per hectare;
 - the pre-1974 classification of rural and urban districts for Great Britain* with rural districts and further subdivided into those which were truly rural or semi-rural;
 - a subjective assessment made by OPCS field staff conducting the interviews in the areas concerned.
- Having combined these three measures and examined their relationship we found that up to a point there was a reasonable degree of consistency.

The main problem however was how to deal with cases where the three sets of data appeared contradictory. The district classification, which in any case contained many incongruities even prior to 1974, showed a high proportion of inconsistencies in areas which had been further identified as semi-rural. The analysis also showed that population density was most likely to be consistent with the other data in very high or low ranges.

In the event the classification of 'rural' used for the survey was identified as follows:

- areas where
 - the interviewer's assessment was *rural*;
 - the ward density was less than 15 persons per hectare; and
 - the pre-1974 classification of the area was *rural*;
- 17%

* Information about Northern Ireland was based on current definitions of urban and rural districts.

§ A rural district which had less than 0.25 persons per hectare and which was not contiguous with an urban area having a population of 25,000 or more was defined as truly rural.

Table 2.6 Age, sex and social class by region and country

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
Age	%	%	%	%	%	%	%	%	%
16-24	16	15	13	15	15	16	17	21	15
25-34	18	19	19	20	19	13	16	18	18
35-44	16	15	15	18	16	18	16	14	16
45-54	17	18	18	15	17	16	14	15	17
55-64	15	16	16	13	15	20	16	18	15
65-74	13	12	14	11	13	10	14	7	12
75 or over	6	6	5	8	6	8	6	8	6
Total	100	100	100	100	100	100	100	100	100
Sex									
Male	45	48	47	46	46	50	46	42	46
Female	54	52	54	54	53	50	54	58	54
Total	100	100	100	100	100	100	100	100	100
Social class									
I	5	4	8	8	6	7	4	5	6
II	24	23	23	27	24	23	14	28	23
III non-manual	11	8	13	9	10	9	10	7	10
III manual	32	37	32	33	34	35	41	24	34
IV	17	18	14	16	16	15	19	12	16
V	7	5	5	3	5	6	7	13	6
Not classified/ never worked	4	4	4	4	4	5	5	10	4
Total	100	100	100	100	100	100	100	100	100
Weighted base	1056	936	1067	568	3627	204	392	120	4343

b) areas where

- i) the interviewer's assessment was *rural*;
- ii) the ward density was less than 15 persons per hectare; but
- iii) the pre-1974 classification of the area was *urban*.

6%

All other areas were classified as *non-rural* although it must be stressed that this category would cover a number of very different types of area. It would, for example, include high density inner city areas, small towns and possibly some areas which were partly rural. From this it can be seen that the classification attempts only to identify rural areas, but does not, conversely, identify areas which are urban.

We have no way of checking this classification and there will almost certainly be some anomalies within it. However the distribution shown in Table 2.7 suggests that the proportion of the sample identified as living in 'rural' areas is of the order of magnitude that would be expected from previous statistics about rural districts.

Table 2.7 Distribution of samples, by rural/non-rural areas

Area	Total sample (16 and over)
Rural areas	% 23
Non-rural areas	76
Total	100
Weighted base	4343

Table 2.8 shows the proportion of people identified as living in rural and non-rural areas for each region and country. It can be seen that England shows a relatively low proportion living in rural areas while in Northern Ireland the proportion is almost twice as high as anywhere else in the UK. Within England the region showing the highest proportion of people living in rural areas is the Midlands.

2.4 Aids to access

For each topic of enquiry, we have examined the distances which people have to travel to obtain health services and, in most cases the means of transport they would usually use to get there. In this context it was useful to know the extent to which the informants had the use of, or access to, a car or van. Another facility which can have a bearing on accessibility is the use of a

Table 2.9 Use of car and telephone, by rural and non-rural areas

	Rural areas	Non-rural areas	Total
	%	%	%
Informant has use of car/van	53	37	41
Car/van in household—not driven by informant	21	21	21
No car/van in household	23	38	34
Not known	3	3	3
Total	100	100	100
Own telephone in home	62	64	63
No telephone but would use:			
public call box	18	20	19
neighbour's phone	13	10	11
phone from somewhere else	2	1	1
Never use telephone	—	—	—
Not known	5	5	5
Total	100	100	100
Weighted base	1030	3313	4343

telephone and we therefore asked the informants if they had a telephone in their homes and if not, what they usually did if they wanted to make a call when they were at home.

The information provided about private cars and telephones is shown in Table 2.9 analysed by the type of area the person lived in. In 41% of cases the person interviewed had the use of a private car and an additional 21% of people said there was a car in the household although they themselves did not drive. It can be seen that in rural areas the proportion of people having personal use of a car was substantially higher than in non-rural areas, 53% compared with 37%.

With respect to the telephone 63% of informants said that they had a telephone in the home, 19% had not and said they would use a public call box if they needed to telephone and 11% said they would use a neighbour's phone. In terms of access to the telephone there was no difference between people living in rural areas and those in non-rural areas.

For both car and telephone availability it is also of interest to see what variation occurs for people of different ages. Table 2.10 shows the situation with respect to cars, and includes data separately for males and females since a much higher proportion of men than of women drive.

Table 2.11 shows that over half of the total sample had their own telephone, a fact that is reflected in all of the

Table 2.8 Type of area, by region and country

Area	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Rural	20	29	16	26	22	29	29	50	24
Non-rural	80	71	85	74	77	70	71	50	76
Total	100	100	100	100	100	100	100	100	100
Weighted base	1056	936	1067	568	3627	204	392	120	4343

Table 2.10 Use of car, by age and sex

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Informant has use of car/van	42	68	74	66	59	39	13	57
Car/van in household—not driven by informant	26	2	3	6	7	4	15	9
No car/van in household	30	26	18	23	30	53	71	31
Not known	2	3	5	5	4	4	1	4
Total	100	100	100	100	100	100	100	100
Weighted base	332	396	318	325	311	242	93	2020
Females								
Informant has use of car/van	26	46	40	29	19	11	3	27
Car/van in household—not driven by informant	34	28	34	41	37	22	18	32
No car/van in household	38	22	23	26	41	65	76	38
Not known	3	4	2	4	4	2	2	3
Total	100	100	100	100	100	100	100	100
Weighted base	326	398	368	397	356	300	175	2323
Persons								
Informant has use of car/van	34	57	56	46	38	24	7	41
Car/van in household—not driven by informant	30	15	20	25	23	14	17	21
No car/van in household	34	24	21	25	36	59	75	34
Not known	2	4	4	4	4	3	2	3
Total	100	100	100	100	100	100	100	100
Weighted base	658	794	686	722	667	542	268	4343

Table 2.11 Use of telephone by age

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Own telephone in home	59	67	70	69	64	53	48	63
No telephone in home but would use:								
public call box	26	20	17	15	21	19	10	19
neighbour's phone	9	7	9	9	10	18	25	11
phone from somewhere else	1	1	..	1	1	3	8	1
Never use telephone	—	—	..	—	..	1	2	..
Not known	5	5	3	5	4	7	7	5
Total	100	100	100	100	100	100	100	100
Weighted base	658	794	686	722	667	542	268	4343

Table 2.12 Use of car by social class

Table 2.12 Use of car by social class							Total
Social Class							
Non-manual			Manual				
I	II	III	III	IV	V		
	%	%	%	%	%	%	
Informant has use of car/van	69	59	38	40	24	13	41
Car/van in household—not driven by informant	18	20	19	23	21	13	21
No car/van in household	10	16	40	33	53	72	35
Not known	2	5	4	4	2	2	3
Total	100	100	100	100	100	100	100
Weighted base	255	990	438	1468	706	250	4289

Table 2.13 Use of car by social class and age

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Non-manual	%	%	%	%	%	%	%	%
Informant has use of car/van	40	71	69	61	51	42	12	55
Car/van in household—not driven by informant	36	12	17	22	20	16	19	20
No car/van in household	20	14	10	12	22	40	67	21
Not known	4	3	3	6	7	3	2	4
Total	100	100	100	100	100	100	100	100
Weighted base	211	332	272	310	264	186	106	1682
Manual								
Informant has use of car/van	31	47	46	34	29	14	3	33
Car/van in household—not driven by informant	28	18	22	27	24	12	14	22
No car/van in household	39	31	28	35	45	71	82	43
Not known	2	4	4	4	2	2	1	3
Total	100	100	100	100	100	100	100	100
Weighted base	392	430	391	378	377	324	127	2424

Table 2.14 Use of telephone by social class

Table 2.14 Use of telephone by social class							Total
Social class							
Non-manual			Manual				
I	II	III	III	IV	V		
	%	%	%	%	%	%	
Has own telephone in house	91	85	73	56	45	32	
Has no telephone	9	15	27	44	55	68	
Total	100	100	100	100	100	100	
Weighted base	255	990	438	1468	706	250	
						4289	

Table 2.15 Possession of car by social class and age

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Non-manual	%	%	%	%	%	%	%	%
Informant's household has car/van	77	83	87	83	71	58	31	75
has no car/van	20	14	10	11	22	39	67	21
not known	4	3	3	5	7	3	2	4
Total	100	100	100	100	100	100	100	100
Weighted base	216	336	276	315	268	188	108	1707
Manual								
Informant's household has car/van	59	64	68	61	53	27	17	54
has no car/van	40	32	28	35	45	71	81	43
not known	2	4	4	4	2	2	2	3
Total	100	100	100	100	100	100	100	100
Weighted base	400	435	395	378	378	326	128	2444

age groups except that of the eldest where just under half had one. One in four of the very elderly stated that they would use a neighbour's telephone if necessary while fewer than 10% of the younger adults said this. People aged 16-64 were more likely to use a public call box if they did not have their own telephone.

Social class as well as age is related to the possession of both cars and telephones, so that those in the non-manual group were more likely than others to possess each. Table 2.12 shows, for example, that whilst only 10% of the people in Class I had no car available to the household, the figure was 72% for those in Class V—although the availability of a car was rather greater in Class III manual than in Class III non-manual. Even greater differences appear if age is also taken into ac-

count. Thus, at the extremes, 10% of the non-manual group aged 35-44 had no car, but as much as 82% of the manual group aged 75 or more (Table 2.13).

In the case of telephones, only 9% of informants in Class I had none in their homes, compared with nearly 70% of those in Class V (Table 2.14).

Other things being equal, the elderly and the manual group—notably those in Classes IV and V have a relative disadvantage in their access to any service because they are less likely to possess cars or telephones.

Reference

¹ OPCS. *General Household Survey 1976*. HMSO, 1978.

PART II GENERAL MEDICAL PRACTICE

3 The use of different types of practice

3.1 Introduction

The developments in general practice which have occurred over the last two decades and are described in Chapter 1 were advocated because it was believed that they would improve the efficiency of the service in a variety of ways. It is, however, possible that increasing rationalisation has brought concomitant disadvantages and in this respect we are concerned specifically with whether it has reduced the accessibility of general practitioners to their patients. Accessibility, in the sense used here, involves not only objective facts, like the distance of surgeries from people's homes, but also their assessment of the ease or difficulty of consulting their doctors. The latter is important because it depends not only on people's personalities and expectations, but also on the web of circumstances which enmesh them and which cannot be captured by investigations of this kind. Someone who finds it difficult, say, to travel a relatively short distance to his/her doctor may do so not because of transport problems or age, which we take into account, but because of other pressures on their lives which are unknown to us, although they might be inferred if such apparent inconsistencies were most prevalent in certain groups.

The most satisfactory way to assess the impact of developments in general practice would be to examine changes in peoples' experiences over time, as Cartwright and Anderson have done¹. This was not possible in the present case, and instead we concentrate on showing how people's experiences differ according to the kind of practice they use, whether it is of the more traditional or more recent type, represented by the larger group practices and those in health centres, and also according to the number of patients on the doctors' lists—a subject of perennial interest.

The best means of finding whether accessibility is adequate would be in terms of health: that is to say, whether a certain degree of difficulty of access results in the prolongation of illness or in complications which would otherwise be prevented. This would be an immensely difficult task even if it could be done at all and is not attempted here. Instead we shall consider later in Part II the frequency of consultations, and ask whether the characteristics of the practices used and their accessibility affected the number of consultations made.

The present chapter is purely descriptive and shows the proportions of people using different kinds of practice

and the way this varies with where they live in the United Kingdom and with their own social and demographic characteristics.

3.2 The way the practices were classified

The items used to classify practices were as follows:

Number of principals.

Total list size (that is, number of patients registered with practice).

Whether practice was based in a health centre provided by the Area Health Authority or Health Board.

The Medical Practices Committee classification of the area in which the practice was located.

In addition, practices are grouped according to whether they had branch surgeries or not, but since this is only relevant to their physical accessibility, the evidence is not dealt with here but can be found in Chapter 4.

As described in Chapter 1, the information necessary for classifying practices was obtained from Family Practitioner Committees (FPCs) and Health Boards. Where the information was unobtainable (for example, because informants did not give the name and address of their doctors' practices, or general practitioners were unwilling for the information to be released) substitute information was used as shown below.

<i>Item</i>	<i>Substitute</i>
Number of principals	patient's report of number of doctors in practice (Q5)
List size	none available
Health centre	patient's report (Q52b)
MPC area	information obtained from MPC for sampling purposes

The number of cases for which substitute information had to be used varied with the item concerned but was never more than 6% of those registered with general practitioners (99% of the sample were registered).

The degree of accuracy of the substitute information is suggested by comparing informants' reports with FPC data, where both were available. Thus:

About three-quarters of those registered with practices of five or less doctors reported practice size correctly.

About half the people registered with practices of six or more doctors reported the correct number, the remainder tending to make an underestimate.

About 80% of those registered with practices located in health centres reported this. Five per cent of informants registered with other practices incorrectly said they were in health centres.

In the small proportion of cases where substitute information was used, there is therefore likely to be some error, but as most reports will be correct it seemed more useful to use them than to exclude the cases from the analyses.

The items used to classify the practices were sub-divided as follows:

Number of principals in practice

These were grouped in a condensed form of the categories used in official health statistics:

- Single-handed practice;
- 2-3 principals;
- 4-5 principals;
- 6 or more principals.

List size

The average list size per doctor was calculated by dividing total list size by the number of principals in the practice. The resulting average sizes were arranged in groups based on the systems formerly* used by the Medical Practices Committees of England and Wales, to define different types of practice area (see below):

- up to 1800 patients;
- 1801-2100 patients;
- 2101-2500 patients;
- 2501-3000 patients;
- more than 3000 patients.

The classification differs from that of the MPC not only because it is based on the average list size of doctors in a practice rather than in a practice area but also because the MPC classification is based on what the average list size would be if one additional doctor worked in the area.

Whether practice is located in health centre

Obtained from FPC or Health Board.

Type of area

As described above the MPC for England and Wales formerly classified areas on the basis of average list size, as follows:

<i>Average list size</i>	<i>Type of area</i>
up to 1800	Restricted
1801-2100	Intermediate
2101-2500	Open
more than 2500	Designated

* There have been slight changes since 1975.

Information obtained from FPCs forms the basis of this classification.

In Scotland areas are classed only as Designated or not Designated, and Designated is defined slightly differently from in England.

In this report only two categories will be used:

'Designated' and 'Non-designated' (the former definition has not been altered since 1975). In designated areas an initial practice allowance is made available to eligible doctors in order to attract additional doctors to the areas.

Before going on to describe the pattern of practice use, it is important to stress that the survey is based on a sample of people and not of practices. This means that the findings refer to the proportions and characteristics of people using different types of practice, and not to the proportions of practices which are of different types. The distinction can be illustrated by the example of single-handed practices. In England 39% of all practices were single-handed in 1976², but only 17% of the sample attended single-handed practices.

3.3 Area of residence and use of different types of practice

In what follows, the use of different practice types will be shown firstly for the United Kingdom as a whole and its four constituent countries, and secondly for the four major regions of England.

The United Kingdom and its four countries

a) Number of principals in practice.

In terms of the categories used, the largest single group of informants in the UK as a whole (43%) used practices of two to three doctors, and the great majority (over 70%) used those with two to five. Only 11% used the largest practices. Thus although, as official show, there has been some increase in large practices,* they are still used by only a small minority of the population.

There was little variation between the three countries of Great Britain in the size of practice used, but informants in Northern Ireland were considerably less likely than others to be using large practices, and only 1% were patients of practices comprising six or more doctors.†

b) Average list size.

A minority of informants used practices with the smallest and largest list sizes; 11% and 17% respectively.

In this case there were marked variations between the

* In England, for example, the proportion of partnerships which were of five or more principals increased from 3% to 8% between 1966 and 1976.²

† This accords with the fact that there is a lower proportion of large practices in Northern Ireland than in England (the only two countries for which these figures are published). In the former 3% of practices comprise five or more doctors, compared with 8% in England.^{2,3}

countries comprising both Great Britain and the UK. Specifically, people living in Wales or Scotland were less likely than others to be on the largest lists of more than 3000 patients, whilst informants in England were the most likely to be so. This is consistent with the average list sizes of practices in England, Wales and Scotland which in 1976 were: 2351, 2199 and 1928 respectively.⁴

c) Health centres

Around 20% of the informants used practices in health centres, and the proportion varied little between the countries of Great Britain. In Northern Ireland, however, where the government has vigorously promoted the establishment of health centres, over half the patients used practices in health centres.

d) Designated areas

The classifications of the MPCs of England and Wales or of Scotland are not used in Northern

Ireland. Practices in designated areas were used by 16% in England and by virtually none in Wales.

The classification 'designated', as described earlier, is largely determined according to the average list size of the practice area and is applied to those having lists which average more than 2500 patients. Table 3.1 shows that use of practices with lists of this size were commonest in England and it was therefore to be expected that use of practices in designated areas would also be commonest in England, as it was.

There was, however, little difference between Scotland and Wales in the proportions of informants on lists of over 2500, with a slightly higher proportion in Wales doing so. It was therefore surprising that whilst virtually none of the Welsh informants were using practices in designated areas, 9% of the Scottish sample were doing so.

In fact, as Table 3.2 shows, in both England and Scotland people using practices in designated areas were

Table 3.1 Size of practices attended, by country

	England	Wales	Scotland	Northern Ireland	Total UK
	%	%	%	%	%
(a) Number of principals in practice attended:					
Single doctor	17	17	14	20	17
2-3 doctors	42	41	47	61	43
4-5 doctors	29	32	26	18	29
6 or more doctors	11	9	13	1	11
Not known	..	..	..	..	..
Total	100	100	100	100	100
(b) Average list size of practice attended:					
up to 1800	10	13	25	15	11
1801-2100	13	29	26	16	15
2101-2500	26	28	29	35	27
2501-3000	28 } 47	26 } 25	12 } 17	18 } 31	25 } 42
More than 3000	19 } 5	5	5	13 } 3	17 } 5
Not known	5	5	2	3	5
Total	100	100	100	100	100
(c) Practice attended:					
In a health centre	17	21	22	54	19
Not in a health centre	82	78	77	45	80
Not known	1	1	1	1	1
Total	100	100	100	100	100
(d) Practice attended in:					
MPC designated area	16	..	9	—	14
Non-designated area	84	99	91	100	87
Total	100	100	100	100	100
Base: All NHS registered	3576	203	391	119	4289

Table 3.2 Type of practice attended in designated areas and non designated areas

Average list size	England		Scotland		UK	
	Designated area	Non-designated area	Designated area	Non-designated area	Designated area	Non-designated area
	%	%	%	%	%	%
Up to 1800	3	11	7	26	4	12
1801-2100	2	15	18	27	3	17
2101-2500	13	29	47	28	15	29
2501-3000	38 } 79	26 } 41	19 } 25	11 } 16	37 } 77	24 } 37
3000 or more	41 } 5	15	6	5	40 } 2	13 } 5
Not known	2	5	3	2	2	5
Total	100	100	100	100	100	100
Base: All NHS registered	575	3001	34	357	610	3679

more likely than others to be on lists of over 2500 patients; but whereas the difference in Scotland was that between 25% and 16%, in England it was very much greater, the proportions being 79% and 41% respectively. Since only a quarter of the Scottish sample using practices in designated areas were on lists of the criterion size, it is possible that other factors carried more weight in the classification of areas in Scotland.*

England and its four major regions

a) Number of principals in practice

As in the United Kingdom sample as a whole, single-handed practices were used by 17% of informants living in England and those of six or more doctors by 11%. (Table 3.3.) There was some variation between the regions, with people in the South West being the most, and those in the North the least, likely to be using the larger practices of four or more doctors.

b) Average list size

As was shown earlier, people in England were more likely than those in the rest of the UK to be on large lists and 47% were on lists of over 2500 patients. § Within England the proportion on lists of this size

* It is also possible that the sample was oddly distributed within designated areas in Scotland since it was small, although as will be remembered twice as large as it appears on the tables (see Chapter 2). Unlike for England and Wales, official statistics for Scotland do not show average list size for designated and other areas separately, and there is therefore no means of checking our conclusions.

§ Strictly speaking, the 47% were using practices where the average list size was over 2500. Some of them may actually have been on smaller lists if the specific doctor with whom they were registered had a smaller patient list than the average for the practice.

was greatest in the North (55%) and lowest in the South West (29%).

c) Health centres

Practices in health centres were used by 17% of the total English sample, and although there was no marked variation, their use appeared to be most common in the South West and least so in the South East.

d) Designated areas

The proportion using practices in designated areas were greatest in the North and Midlands and least in the South West. This accords reasonably well with the proportions in each region using practices with list sizes of over 2500.

3.4 Differences between rural and non-rural areas

There were some differences in the extent to which each kind of practice was used between those living in rural areas and others, but none was great (Table 3.4). People in rural areas were slightly less likely than others to use single-handed practices, to be on lists of over 2500*, or to be patients of practices in designated areas. On the other hand, they were slightly more likely to be using practices in health centres.

Not only were the differences rather small, but their direction was reversed for some of the countries of the UK (Table 3.5). For example, in Scotland and Wales use of single-handed practices was commoner in rural than

* See note §

Table 3.3 Size of practices attended, by region

	North	Midlands	South East	South West	Total England
	%	%	%	%	%
(a) Number of principals in practice attended:					
Single doctor	17	16	22	9	17
2-3 doctors	50	37	42	39	42
4-5 doctors	23	36	26	36	29
6 or more doctors	9	11	10	17	11
Not known	..	..	1	..	..
Total	100	100	100	100	100
(b) Average list size of practice attended:					
Up to 1800	8	7	12	11	10
1801-2100	11	9	14	19	13
2101-2500	22	26	26	36	26
2501-3000	33	29	25	18	28
More than 3000	22	20	19	11	19
Not known	3	8	4	4	5
Total	100	100	100	100	100
(c) Practice attended:					
In a health centre	21	16	11	23	17
Not in a health centre	78	84	88	76	82
Not known	1	1	1	1	1
Total	100	100	100	100	100
(d) Practice attended in:					
MPC designated area	23	23	9	5	16
Non-designated area	77	78	91	94	84
Total	100	100	100	100	100
Base: All NHS registered	1049	927	1049	551	3576

Table 3.4 Type of practice attended in rural and non-rural areas

	Rural areas	Non-rural areas	All areas
Number of principals in practice attended:	%	%	%
Single doctor	11	19	17
2-3 doctors	44	43	43
4-5 doctors	32	28	29
6 or more doctors	13	10	11
Not known	..	..	..
Total	100	100	100
Average list size of practice attended:			
Up to 1800	15	10	11
1801-2100	15	15	15
2101-2500	31	26	27
2501-3000	22	26	25
More than 3000	10	19	17
Not known	7	4	5
Total	100	100	100
Practice attended:			
In a health centre	23	17	19
Not in a health centre	76	82	81
Not known	1	1	1
Total	100	100	100
Practice attended in:			
MPC designated area	9	16	14
Non-designated area (including N. Ireland)	91	84	86
Total	100	100	100
Base: all NHS registered	1008	3281	4289

in other areas. Nor, as Table 3.6 shows, did all the differences apply to every English region.

3.5 Relationships between the characteristics of the practices used

People using single-handed practices are the most likely to be on lists of over 2500 patients,* but there was no

* See note § on page 15.

systematic variation of list sizes with the number of doctors (Table 3.7).

The term health centre might suggest premises from which large numbers of doctors operate, but although a rather greater proportion of the people using health centres than others were patients of practices with four or more doctors (49% compared with 37%) there was no difference in the proportion having six or more, and 10% of those using health centres were attached to single-handed practices (Table 3.8a).

There was no clear indication that using a health centre involved being on a larger or smaller list than using practices located elsewhere (Table 3.8b).

3.6 Do different kinds of people use different kinds of practice?

Apart from its intrinsic interest, the question is relevant to the relationship between type of practice and accessibility. If, for example, it were true that the elderly, who are less mobile than other people, tended to use a certain kind of practice more than other kinds, that type of practice might appear to be less accessible than others, purely because of the characteristics of the people most prone to use it.

In fact, as Tables 3.9 to 3.12 show, there was virtually no difference between the kinds of people using different types of practice: the distributions by age, sex and social class were almost identical for every type of practice.

The evidence that there were no social class differences is in fact remarkable, for it is rare to find none in any area of social research, including that of service use. It might have been expected, in particular, that people in Social Classes IV and V would be more likely than

Table 3.5 Type of practice attended in rural and non-rural areas, by country

Proportion of informants attending:	England	Wales	Scotland	Northern Ireland	Total UK
	%	%	%	%	%
Single-handed practice—					
rural	8	30	20	12	11
non-rural	20	12	11	28	19
4 or more doctors in practice—					
rural	51	22	31	19	45
non-rural	37	49	42	18	38
Practice with average list size up to 1800—					
rural	13	25	30	10	15
non-rural	9	8	22	20	10
Average list size over 2500—					
rural	36	33	11	36	33
non-rural	49	22	19	25	45
Practice in a health centre—					
rural	22	2	26	59	23
non-rural	16	29	21	48	17
Practice in a designated area—					
rural	11	2	3	Does not apply	9
non-rural	17	—	11		16
Base: All NHS registered					
rural	776	60	113	59	1008
non-rural	2800	143	278	60	3281

Table 3.6 Type of practice attended in rural and non-rural areas, by region

Proportion of informants attending:	North	Midlands	South East	South West	Total England
	%	%	%	%	%
Single-handed practice—					
rural	9	8	6	8	8
non-rural	20	19	25	9	20
4 or more doctors in practice—					
rural	36	57	54	57	51
non-rural	32	42	33	51	37
Practice with average list size up to 1800—					
rural	11	11	12	20	13
non-rural	7	6	12	8	9
Average list size over 2500—					
rural	49	35	36	17	36
non-rural	57	55	45	33	49
Practice in a health centre—					
rural	27	23	6	29	22
non-rural	20	13	12	21	16
Practice in a designated area—					
rural	17	11	10	3	11
non-rural	25	27	8	6	17
Base: All NHS registered					
rural	208	265	162	141	776
non-rural	841	662	887	410	2800

Table 3.7 List size of practice attended, by number of doctors in practice

Average list size of practice attended	Number of doctors in practice attended				Total
	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	
	%	%	%	%	%
Up to 1800	11	16	7	3	11
1801-2100	13	16	13	18	15
2101-2500	18	26	33	35	27
2501-3000	24 } 53	21 } 38	31 } 43	30 } 40	25 } 42
More than 3000	29	17	10	10	17
Not known	5	4	4	4	5
Total	100	100	100	100	100
Base: All NHS registered	724	1833	1230	466	4289

Table 3.8 Size of practice attended, by whether sited in a health centre or not

	In health centre	Not in health centre	Total
	%	%	%
(a) Number of principals in practice attended:			
Single handed	10	19	17
2-3 doctors	41	44	43
4-5 doctors	39	26	29
6 or more	10	11	11
Not known	..	..	..
Total	100	100	100
(b) Average list size of practice attended:			
Up to 1800	10	12	11
1801-2100	14	15	15
2101-2500	26	28	27
2501-3000	29 } 45	25 } 42	25 } 42
over 3000	16	17	17
Not known	4	4	5
Total	100	100	100
Base: All NHS registered	802	3454	4289

others to be on the largest lists—which is widely considered to be a disadvantage. But this was not the case; the proportions using practices with lists in each size group were the same.

3.7 Summary

In the UK as a whole 11% of patients used practices with six or more doctors, 42% of those with average list sizes of over 2500 patients, 19% attended a practice in a health centre and 14% used one in a designated area. The most marked differences from the overall pattern occurred in Northern Ireland, where 1% used a practice with six or more doctors and 54% attended a practice at a health centre (there are no designated areas in Northern Ireland). Lists of more than 3000 were relatively uncommon in Wales and Scotland (5% in each compared with 19% in England and 13% in Northern Ireland). Practices in designated areas were attended by a greater proportion of people in England than of those

Table 3.9 Age and sex of informants attending different size practices

Age	Number of principals			Average list size			Total
	Single doctor	2-3 doctors	4 or more	Low: up to 2100	Medium: 2101-2500	High: 2501 or more	
Males	%	%	%	%	%	%	%
16-24	16	16	16	17	15	16	16
25-34	15	20	21	19	19	20	19
35-44	17	16	15	14	17	16	16
45-54	17	16	17	15	17	16	16
55-64	18	15	15	16	15	16	16
65-74	12	14	10	14	13	10	12
75 and over	5	4	5	5	3	5	5
Total	100	100	100	100	100	100	100
Base: NHS registered males	342	862	772	507	552	830	1986
Females							
16-24	15	14	13	12	15	14	14
25-34	15	17	18	17	20	16	17
35-44	13	16	16	15	15	17	16
45-54	17	17	18	17	16	18	17
55-64	16	16	14	15	15	15	15
65-74	15	11	14	14	12	13	13
75 and over	9	8	6	10	6	7	7
Total	100	100	100	100	100	100	100
Base: NHS registered females	382	990	925	612	610	982	2303
Persons							
16-24	15	15	15	14	15	15	15
25-34	15	18	20	18	19	18	18
35-44	15	16	16	14	16	16	16
45-54	17	16	17	16	17	17	17
55-64	17	16	15	15	15	16	15
65-74	14	12	12	14	13	12	12
75 and over	7	6	5	8	5	6	6
Total	100	100	100	100	100	100	100
Base: All NHS registered	724	1833	1696	1120	1162	1812	4289

Table 3.10 Age and sex of informants attending practices in health centres and designated areas

Age	Attends practice:		Attends practice:		Total
	In health centre	Not in health centre	In designated area	Not in designated area	
Males	%	%	%	%	%
16-24	13	17	16	16	16
25-34	22	19	21	19	19
35-44	17	15	17	16	16
45-54	18	16	18	16	16
55-64	15	16	12	16	16
65-74	11	12	10	12	12
75 and over	4	5	5	4	5
Total	100	100	100	100	100
Base: NHS registered males	372	1597	294	1692	1986
Females					
16-24	15	14	15	14	14
25-34	17	17	17	17	17
35-44	19	15	15	16	16
45-54	18	17	19	17	17
55-64	14	16	13	16	15
65-74	11	13	15	13	13
75 and over	6	8	6	8	7
Total	100	100	100	100	100
Base: NHS registered females	430	1856	316	1987	2303
Persons					
16-24	14	15	15	15	15
25-34	19	18	19	18	18
35-44	18	15	16	16	16
45-54	18	16	19	16	17
55-64	15	13	13	16	15
65-74	11	13	12	12	12
75 and over	5	6	6	6	6
Total	100	100	100	100	100
Base: All NHS registered	802	3454	610	3679	4289

Table 3.11 Social class of informants attending different size practices

Social class	Number of principals			Average list size			Total
	Single doctor	2-3 doctors	4 or more	Up to 2100	2101-2500	2501 or more	
	%	%	%	%	%	%	%
I	5	6	7	5	8	6	6
II	22	22	25	23	24	22	23
III non-manual	10	11	9	11	10	10	10
III manual	34	35	34	33	33	36	34
IV	19	16	16	17	17	16	16
V	6	6	6	6	5	6	6
Not known/never worked	4	5	4	5	3	4	4
Total	100	100	100	100	100	100	100
Base: All NHS registered	724	1853	1696	1120	1162	1812	4289

Table 3.12 Social class of informants attending practices in health centres and designated areas

Social class	Attends practice:		Attends practice:		Total
	In health centre	Not in health centre	In designated area	Not in designated area	
	%	%	%	%	%
I	7	6	4	6	6
II	24	23	20	24	23
III non-manual	10	10	10	10	10
III manual	33	34	38	34	34
IV	17	16	16	17	16
V	6	6	6	6	6
Not known/never worked	4	4	5	4	4
Total	100	100	100	100	100
Base: All NHS registered	802	3454	610	3679	4289

in Wales or Scotland. There were differences between the four regions of England, people using single-handed practices, those with large lists and in designated areas being least common in the South West. Rural areas as a whole included a lower percentage of people using single-handed doctors and lower percentages on large lists and in designated areas.

There was virtually no difference between the sex, age

and social class of people using the different types of practice.

References

- ¹ Ann Cartwright and Robert Anderson. *Patients and their doctors in 1977*. Institute for Social Studies in Medical Care. 1978.
- ² DHSS. *Health and Personal Social Service Statistics for England, 1977*. HMSO. 1977. p 62.
- ³ Common Services Agency. *Annual Report, 1976*. p 27.
- ⁴ CSO. *Annual Abstract of Statistics, 1977*. HMSO. 1977. pp 78-79.

4 Accessibility of doctors' surgeries

4.1 Introduction

Before considering distances and journeys to surgeries in detail, it is worth pointing out that the vast majority (over 90%) of those questioned said they found it very or fairly easy to reach their doctor's surgeries. The physical accessibility of surgeries nevertheless merits examination because, as mentioned earlier, the recent trend towards the clustering of doctors into group practices and the growth of multiple-service health centres is likely to have increased the distance between people's homes and the surgeries they use. One of our main purposes in this chapter, therefore, is to discover whether, in fact, the larger practices and those in health centres are less accessible than others.

Apart from recent developments in the organisation of the service, accessibility is almost certain to vary with people's circumstances and the area in which they live. Accordingly, the second objective here is to show for which groups of people surgeries were least accessible.

4.2 Branch surgeries

Thirty-five per cent of the sample attended practices with branch surgeries; that is to say, doctors in the practices held some of their surgeries at sites other than their main premises.

The information about branch surgeries comes from the Practice Information Sheet (see Chapter 1) and although informants were asked whether their doctor held surgeries at more than one place, only half of those attached to practices with branch surgeries answered that he did*. The main purpose of asking informants

* Since informants were asked about 'your doctor' rather than 'doctors in the practice you attend', some of them may have been correct in saying that their *own* doctor did not hold surgeries at different places.

the question, however, was to find out whether those attending practices with branch surgeries used more than one of them, in which case the ensuing questions about distances and journeys to surgeries would have caused difficulties. In fact, virtually everyone who reported that their doctor held surgeries in different places said there was one surgery which they usually used. For the people who use practices with branch surgeries therefore, the reported accessibility is that of the one usually used, whether or not it was the main surgery.

The substantive point about branch surgeries is that they may mitigate the possible disadvantages of organisational clustering. The extent to which they do so, depends on whether branch surgeries are most prevalent amongst the larger practices and those located in health centres. As Table 4.1a shows, the proportions of people using practices with branch surgeries increased with the number of doctors in the practice up to the point where there were four or five, from 15% to 44%, and then, strangely, fell somewhat to 37%. People using health centres were no more likely than others to have branch surgeries available to them (Table 4.1b).

One of the most obvious geographical influences on accessibility is likely to be residence in rural areas, but the inherent problems of provision in relatively sparsely populated districts may to some extent be alleviated by the greater availability there of branch surgeries. As can be seen in Table 4.2, half the people living in rural areas compared with less than a third of those living elsewhere used practices with branch surgeries. The difference applied regardless of the number of doctors in the practice but was most marked for those using single-handed practices: in this case over a third of the people

Table 4.1 Whether practice attended has branch surgeries, by number of doctors in practice and whether in a health centre or not

	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
(a)	%	%	%	%	%
Attends practice which has: main surgery only	85	63	56	63	65
branch surgeries	15	37	44	37	35
Total	100	100	100	100	100
Base: All NHS registered	724	1853	1230	466	4289

	In health centre	Not in health centre	Total
(b)	%	%	%
Attends practice which has: main surgery only	66	64	65
branch surgeries	34	36	35
Total	100	100	100
Base: All NHS registered	802	3454	4289

Table 4.2 Whether practice attended has branch surgeries, by number of doctors in practice, in rural and non-rural areas

Attends practice which has	Rural				Non-rural				All rural areas	All non-rural areas	Total
	Single doctor	2-3 doctors	4-5 doctors	6 or more	Single doctor	2-3 doctors	4-5 doctors	6 or more	%	%	%
	%	%	%	%	%	%	%	%			
Main surgery only	64	51	46	48	89	66	60	70	50	69	65
Branch surgeries	36	49	54	52	11	34	40	30	50	31	35
Total	100	100	100	100	100	100	100	100	100	100	100
Base: All NHS registered	110	442	318	135	614	1411	912	331	1008	3281	4289

in rural areas but only around 10% of others had the possibility of using branch surgeries. The effect of branch surgeries on accessibility will be shown in later sections about area of residence and type of practice.

4.3 The accessibility of surgeries

In what follows the various aspects of accessibility to be considered will be: distance to the surgery, the duration of journeys, means of transport and how easy or difficult informants found the journey to be.

The measure of distance from people's homes to the surgeries is derived from informants' own reports, but checks carried out at the pilot stage suggested some accuracy in the estimates given.

Rural and non-rural areas

About half the informants lived within one mile of their doctors' surgeries and three-quarters lived within two miles. Only 5% had to travel five miles or more (Table 4.3).

Table 4.3 Distance of doctor's surgery from home, in rural and non-rural areas

Distance	Rural		Non-rural areas		All areas	
	%	%	%	%	%	%
Less than 1 mile	33	54	49	49	49	49
1 mile up to 2 miles	18	29	26	26	26	26
2 miles up to 5 miles	36	15	20	20	20	20
5 miles or more	12	2	5	5	5	5
Not known	..	1	..	..	..	..
Total	100	100	100	100	100	100
Base: All NHS registered	1008	3281	4289	4289	4289	4289

As expected, distances to surgeries were greater in rural than in other areas, so that nearly half the country-dwellers had to travel at least two miles, compared with only a sixth of those living elsewhere.

Table 4.4 Distance of doctor's surgery from home, by whether practice has branch surgeries, in rural and non-rural areas

Distance	Rural		Non-rural		All areas	
	Practice has branch surgery	Main surgery only	Practice has branch surgery	Main surgery only	Practice has branch surgery	Main surgery only
	%	%	%	%	%	%
Less than 1 mile	41	26	57	52	52	47
1 mile up to 2 miles	18	18	26	30	24	28
2 miles up to 5 miles	31	41	14	15	20	20
5 miles or more	10	15	2	2	5	5
Not known	..	..	..	1	..	1
Total	100	100	100	100	100	100
Base: All NHS registered	500	508	1008	2268	1508	2776

For the sample as a whole, using a practice having branch surgeries made little difference to the proximity of the surgery used but in rural areas the effect was considerable, in that only 26% of the people using practices without branch surgeries had to travel less than a mile, compared with 41% of those for whom branch surgeries were available (Table 4.4).

It is perhaps surprising that as many as 17% of the people living in non-rural areas had to travel at least two miles to see their doctor (see Table 4.3), but this may be from choice rather than necessity. The evidence given in Chapter 8, for example, shows that some people who move house remain with their former doctor's practice even though this involves travelling greater distances than they would otherwise have to do. Thus, whilst 25% of all the informants lived two or more miles from the surgeries they used, 34% of the people who had moved in the preceding year and had decided to remain with the same practice lived this distance away.

Countries of the United Kingdom and regions of England

Differences in distances from the surgery between the countries of Great Britain were small and the proportions having to travel at least two miles varied from 23% in England to 28% in Scotland (Table 4.5). People living in Northern Ireland, however, were evidently much more likely than others in the UK to live this distance from the surgery they used; half of them had to travel at least two miles. The Northern Irish sample is small, but the proportion having to travel at least five miles—17%—compares reasonably well with the 13% shown by the official statistics for Northern Ireland¹, and which is still higher than the corresponding and more reliable sample proportions for England and Scotland—4% in both cases.

Distinguishing between rural and non-rural areas in each country reduces the reliability of the figures, and those for Wales and Northern Ireland in particular are open to question. In the case of England and Scotland, where we can be more confident that the samples reflect the experiences of the two populations, it seems that amongst people living in rural areas, those in Scotland, on average, live closer to the surgeries they use, but that in non-rural areas the reverse is true.

Amongst the regions of England, people in the South East are most likely to live within a mile of their doctors' surgeries and this is true for both rural and urban areas. There is little variation between other areas as a whole, but it seems that in rural areas people in the Midlands region are most likely to travel at least two miles to see their doctors.

Type of practice

The greater the number of doctors in the practices they used, the more probable that people had to travel longer distances to reach them. Thus 57% of the people using single-handed practices lived within a mile of the surgery, as compared with only 40% of the people using practices of six or more doctors (Table 4.6). On the other hand, it seemed that people using the largest practices were the least likely to have to travel five or more miles to their doctors. In general the relationship between practice size and distance held in both rural and other areas.

The availability of branch surgeries, as expected, did modify the effect of practice size on distances between home and surgery. Thirty-five per cent of the people using practices of a least six doctors without branch

Table 4.5 Distance of doctor's surgery from home, by region and country—rural and non-rural areas

Distance	North	Mid-lands	South East	South West	England	Wales	Scotland	Northern Ireland	Total UK
Rural areas	%	%	%	%	%	%	%	%	%
Less than one mile	36	26	44	34	34	32	47	3	33
1 mile up to 2 miles	26	15	16	19	19	13	11	22	18
2 miles up to 5 miles	26	44	38	36	36	30	32	48	36
5 miles or more	12	15	2	11	11	25	10	27	12
Not known	1	—	—	—	..	—	..	—	..
Total	100	100	100	100	100	100	100	100	100
Base: NHS registered informants living in rural areas	208	265	162	141	776	60	113	60	1008
Non-rural areas									
Less than one mile	51	52	62	51	55	56	45	48	54
1 mile up to 2 miles	30	30	25	30	28	29	32	27	29
2 miles up to 5 miles	17	15	9	16	14	10	21	18	15
5 miles or more	2	2	2	2	2	4	2	7	2
Not known	..	..	1	..	1	—	..	—	1
Total	100	100	100	100	100	100	100	100	100
Base: NHS registered informants living in non-rural areas	841	662	887	410	2800	143	278	60	3281
All areas									
Less than one mile	48	45	59	46	50	49	45	26	49
1 mile up to 2 miles	29	26	24	28	26	25	26	24	26
2 miles up to 5 miles	19	24	14	21	19	16	24	33	20
5 miles or more	4	5	2	5	4	10	4	17	5
Not known	..	..	1	..	1	—	..	—	..
Total	100	100	100	100	100	100	100	100	100
Base: All NHS registered	1049	927	1049	551	3576	203	391	119	4289

Table 4.6 Distance to doctor's surgery from home, in rural and non-rural areas, by number of doctors in practice

Distance	Rural				Non-rural				All areas			
	Single doctor	2-3 doctors	4-5 doctors	6 or more	Single doctor	2-3 doctors	4-5 doctors	6 or more	Single doctor	2-3 doctors	4-5 doctors	6 or more
	%	%	%	%	%	%	%	%	%	%	%	%
Less than 1 mile	37	37	31	25	60	56	49	46	57	52	44	40
1 mile up to 2 miles	13	18	21	15	24	27	32	37	23	24	30	30
2 miles up to 5 miles	34	33	33	53	12	15	15	17	16	19	20	28
5 miles or more	15	12	15	7	2	2	3	1	4	4	6	3
Not known	—	..	—	—	1	..	1	—	1	..	..	—
Total	100	100	100	100	100	100	100	100	100	100	100	100
Base: All NHS registered	110	442	318	135	614	1411	912	331	724	1853	1230	466

Table 4.7 Distance of doctor's surgery from home, according to whether practice used has branch surgeries and number of doctors in practice

Distance	Branch surgery				No branch surgery				All with branch surgery	All without branch surgery
	Single doctor	2-3 doctors	4-5 doctors	6 or more	Single doctor	2-3 doctors	4-5 doctors	6 or more		
	%	%	%	%	%	%	%	%	%	%
Less than 1 mile	51	55	50	47	58	50	40	35	52	47
1 mile up to 2 miles	22	22	25	24	23	26	33	34	24	28
2 miles up to 5 miles	20	18	19	26	15	19	21	28	20	20
5 miles or more	6	4	5	3	4	5	6	2	5	5
Not known	1	—	1	—	1	—	1	—	—	1
Total	100	100	100	100	100	100	100	100	100	100
Base: All NHS registered	110	693	536	170	614	1160	694	296	1508	2776

surgeries lived within a mile of the surgery, as compared with 47% of those using practices of the same kind with branch surgeries (Table 4.7).

The same kind of difference applied to practices of every size except the single-handed. In the latter case people using doctors with no branch surgery tended to live nearer to the surgery than others, presumably because the only lone doctors to operate branch surgeries are those with very scattered practices.

There was no noteworthy difference in distances from home to surgery between those using health centres and others (Table 4.8).

Table 4.8 Distance of doctor's surgery from home, by whether practice is in health centre or not

Distance	In health centre	Not in health centre	Total
	%	%	%
Less than 1 mile	45	50	49
1 mile up to 2 miles	28	26	26
2 miles up to 5 miles	22	19	20
5 miles or more	5	5	5
Not known	—	—	—
Total	100	100	100
Base: All NHS registered	802	3454	4289

The implication of the evidence is, therefore, that the clustering of doctors has somewhat increased the average distance people have to travel to visit them.

4.4 The relationships between distances, means of travel and duration of journey

In the next section we shall be showing how accessibility varies with people's social and demographic characteristics and this will involve taking account not only of the distance they have to travel but also the means of transport available to them and the way this affects the time required for the journey. It is therefore useful to show first how distance, time, means of transport and perceived ease of access were related to one another in general.

For the remainder of this chapter only the people who had visited their doctor in the preceding five years will be considered. Those who had not done so were not asked about journey times, how they travelled or how easy they found the journey both because it was supposed their answers would be unreliable, and also

because their experiences, even if accurately recalled, would not have related to the current situation. It is worth noting however that the people who had not visited their doctor for at least five years were rather more likely than those who had to report that the surgery was two or more miles from their home (35% compared with 24%). It is therefore possible that distance deterred some of these people from visiting their doctor at all.*

Amongst the people who had been to their doctors in the preceding five years, the great majority (73%) who had to go less than a mile walked there, but for the greater distances most went by car or public transport (Table 4.9). The use of a car rather than public transport was greater for all distances in rural than in other areas, presumably because of the scarcity of transport services in country areas and the higher level of car ownership there (see Table 2.9, Chapter 2).

The greater proportion of country dwellers using a car may well account for the evidence that whilst a much smaller percentage of them than of other people live within a mile of their doctor's surgery—the proportions doing so being 33% and 54% respectively, the difference between the proportions who reported the journey as 'very easy' was not nearly so large: 54% compared with 63% (Table 4.10).

Table 4.11 shows that for people who had to go less than a mile to the surgery, walking and travelling by car were equally likely to be very easy, whilst travel by public transport was less so. Not surprisingly, once the distance increased to a mile or more, the advantage of travelling by car became marked. Whatever the distance, travel by public transport was least likely to be very easy.

The use of different means of transport according to the distance to be covered reduced the effect of greater distances on ease of access not only for country dwellers, but also for those using larger practices. Thus whilst the proportions having to travel less than a mile varied from 57% in the case of people using single-

* It is also possible that they may have received more visits at home from the doctor. The present survey did not investigate this point but in *The elderly at home* (HMSO 1978) Audrey Hunt found that among people aged 65 and over whose journey time to the surgery exceeded 30 minutes, 47% had received a home visit from their doctor during the previous six months, compared with 30% of those whose journey time was five minutes or less. (This survey covered England only.)

Table 4.9 Means of transport usually used to get to doctor's surgery, by distance of surgery from home, in rural and non-rural areas

Usually goes to surgery:	Rural				Non-rural				All areas				Total
	Less than 1 ml	1-2 mls	2-5 mls	5 mls or more	Less than 1 ml	1-2 mls	2-5 mls	5 mls or more	Less than 1 ml	1-2 mls	2-5 mls	5 mls or more	
	%	%	%	%	%	%	%	%	%	%	%	%	%
By walking all the way	71	23	..	1	73	27	4	3	73	26	3	2	43
By public transport	1	14	16	10	4	26	43	23	3	24	32	15	15
By car	26	59	80	87	21	45	50	65	22	47	62	78	39
By other private transport (eg motorbike, bicycle)	1	3	2	—	2	2	2	2	1	2	2	1	2
By other means (eg taxi)	1	1	1	2	..	1	..	4	..	1	1	3	1
Not known	—	—	—	—	..	..	..	2	..	..	..	1	..
Total	100	100	100	100	100	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	308	172	315	110	1628	873	450	67	1936	1045	765	177	3932

Table 4.10 Ease of journey to doctor's surgery by distance of rural and non-rural areas

Journey to doctors is:	Less than 1 mile		1-2 miles		2-5 miles		5 miles or more		All distances		Total
	Rural	Non-rural	Rural	Non-rural	Rural	Non-rural	Rural	Non-rural	Rural	Non-rural	
	%	%	%	%	%	%	%	%	%	%	%
Very easy	77	78	44	53	43	35	36	29	54	63	61
Fairly easy	20	18	49	42	47	56	47	51	38	31	33
Fairly difficult	2	2	5	4	7	7	10	11	5	4	4
Very difficult	1	..	1	1	3	1	6	6	2	1	1
Not known	1	1	1	..	1	1	1	3	1	1	1
Total	100	100	100	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding household)	308	1621	172	870	314	448	110	66	906	3014	3920

Table 4.11 Ease of journey to doctor's surgery, by distance to surgery and means of transport used

Journey to doctor's is:	Distance and means of transport								
	Less than 1 mile			1-2 miles			2-5 miles		
	Walks	Public transport	Car	Walks	Public transport	Car	Walks	Public transport	Car
	%	%	%	%	%	%	No	%	%
Very easy	79	46	79	47	34	63	(5)	22	48
Fairly easy	17	46	17	47	57	34	(14)	61	48
Fairly difficult	2	6	2	5	7	1	(2)	14	3
Very difficult	..	1	..	..	2	1	—	3	1
Not known	1	1	2	1	—	1	—	—	1
Total	100	100	100	100	100	100		100	100
Base: Informants who had been to surgery in previous 5 years (excluding household)	1406	67	420	274	247	492	21	245	475

handed practices to 40% for those using practices of six or more doctors—a difference between percentages of 17, the proportions of the different groups saying it was very easy to reach their surgery varied only from 66% to 58%—a difference of 8 (Table 4.12).

4.5 The accessibility of surgeries to different groups

Age

It is to be expected that elderly people will on the whole find getting to their doctor, like getting about in general, more difficult than other people, not only because of the infirmities of age but also because they are less likely than younger groups to have the use of a car and elderly women are at a particular disadvantage in the last respect (see Table 2.10, Chapter 2).

Because they were less likely to have the use of a car, elderly people were more dependent than others on public transport for getting to their doctor's surgery whatever the distance, as Table 4.13 shows, and they were also less likely than younger people to find the journey very easy, particularly if they were women. For example, amongst people who travelled between one and two miles to the surgery, two-thirds of the men under 45 found the journey very easy, but only one-third of the women aged 65 or more (Table 4.14). In all age groups, however, greater proportions of men than women found journeys very easy, presumably mainly because men are more likely to use a car.

The comparatively low level of car usage amongst elderly people may be at least as much due to their generation as to people's reluctance or inability to own and use cars as they grow old. When those who were over 64 were younger, having a car and being able to drive were less commonplace than today. If the difference is largely generational, the resulting difference in ease of access to GPs will presumably be somewhat reduced over the next few decades*. It will not, however, be eradicated, for even amongst people using a car to get to their doctor, elderly people were the most likely to find the journey difficult. Thus of people travelling two to five miles by car to their doctors' surgeries, 2% of the people under 65 found the journey difficult compared with 15% of people aged 65 or more.

Social class

Ease of access to the surgery also varied somewhat with social class so that whilst 69% of the people in Class I said it was very easy to get there, only 55% of those in

* In *The elderly at home* (HMSO 1978) Audrey Hunt found the 11% of elderly people living in England drove themselves to the doctor's surgery, while 12% were driven by another person (the total, 23% agrees very well with the present survey, bearing in mind that this covers the UK). She also quotes an unpublished survey carried out in 1973 which showed a steady decline in the percentage of licence holders from 54% among those aged 30–39 to 27% among those aged 60–69 and then a sharp drop to 9% among those aged 70 and over. This seems to indicate that future generations of elderly people will include among them an appreciably higher proportion of drivers.

Table 4.12 Ease of journey to doctor's surgery, by number of doctors in practice attended

Journey to doctor's is:	Single doctor	2–3 doctors	4–5 doctors	6 or more doctors	Total
	%	%	%	%	%
Very easy	66	61	58	58	61
Fairly easy	28	32	35	38	33
Fairly or very difficult	5	5	6	3	5
Not known	1	1	1	1	1
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	659	1692	1126	433	3929

Table 4.13 Means of transport used to get to surgery, by distance from home and age of informant

Usually goes to surgery:	16–64				65 and over				Totals	
	Less than 1ml	1–2 mls	2–5 mls	5mls or more	Less than 1ml	1–2 mls	2–5 mls	5mls or more	16–64	65 and over
	%	%	%	%	%	%	%	No	%	%
By walking all the way	71	27	2	2	78	23	4	—	42	50
By public transport	3	20	30	14	6	41	42	(4)	14	21
By car	24	51	64	79	13	29	50	(14)	42	25
By other private transport (eg motorbike, bicycle)	2	2	2	1	..	2	1	—	2	1
In some other way (eg taxi)	..	..	1	3	1	3	1	(1)	1	2
Not known	..	..	—	1	1	2	2	—	..	1
Total	100	100	100	100	100	100	100	—	100	100
Base: Informants who had been to surgery in previous 5 years	1558	866	658	157	375	178	105	19	3246	680

Class V said the same (Table 4.15). This was not because their distance from the surgery varied, but because their use of a car did (see Table 2.12, Chapter 2). Consequently people in the manual group and particularly those in Class V were less likely than others to go to their doctors by car: the proportions doing so in the total non-manual and manual groups being 53% and 30% respectively, whilst only 14% of those in Class V did so.

Amongst those using a car to make the journey there was little difference between social classes particularly when distance from the surgery is taken into account. For example, of the people using a car and living between two and five miles from their doctors' surgery 3% of the non-manual group, 4% of the skilled manual groups and 5% of the semi- and unskilled found the journey fairly or very difficult.

Differences between groups in the ease with which they can reach the surgery become greatest when age, sex and social class are all taken into account. The extremes are illustrated by men under 45 from the non-manual group, on the one hand, of whom about three-quarters could get to their doctors very easily, and women over 75 from the manual group on the other, of whom less than a third said the same (Table 4.16).

4.6 Summary and discussion

Not unexpectedly, for the UK as a whole, the greatest difference in the distances people had to go to visit their doctors lay between rural and other areas. In addition, the larger the number of doctors in the practice used, the more probable that people had to travel further to get there. It therefore seems, as expected, that the clustering of doctors into group practices has somewhat reduced their proximity to people's homes. In both

Table 4.14 Ease of journey to doctor's by distance from home, age and sex

Table 4.14 Ease of journey to doctor's by distance from home, age and sex																																					
Journey to doctor's is:		Less than 1 mile						1 mile less than 2						2 miles less than 5						All distances																	
		16-44			45-64			65 and over			16-44			45-64			65 and over			16-44			45-64			65 and over			16-44			45-64			65-75 & over		
		M	F	%	M	F	%	M	F	%	M	F	%	M	F	%	M	F	%	M	F	%	M	F	%	M	F	%	M	F	%	M	F	%			
		%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%			
Very easy	87	80	80	75	69	58	68	52	60	41	34	32	52	35	40	32	29	18	66	59	53	35	35														
Fairly easy	10	18	17	22	26	28	30	44	37	54	57	48	45	56	54	53	54	30	35	38	40	38															
Fairly difficult	1	1	2	2	4	8	1	3	2	4	7	13	1	7	3	12	17	2	4	6	16	16															
Very difficult	—	—	1	—	1	3	—	—	—	1	1	6	1	1	1	1	6	9	1	2	8	8															
Not known	2	1	1	1	—	2	—	1	—	1	—	1	—	1	—	1	—	2	1	1	1	2	2														
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100														
Base: Informants who had been to surgery in previous 5 years (excluding housebound)																																					
	436	522	274	324	159	211	237	268	174	188	74	102	202	210	100	146	47	56	1978	1264	476	194	194														

Table 4.15 Ease of journey to doctor's by social class

Table 4.15 Ease of journey to doctor's by social class											
Journey to doctor's is:	Non-manual			Manual			Total				
	I	II	IIINM	IIIM	IV	V					
	%	%	%	%	%	%					
Very easy	69	63	61	61	58	55	61				
Fairly easy	28	32	34	33	34	35	33				
Fairly difficult	1	3	4	4	5	6	4				
Very difficult	..	1	1	1	1	..	1				
Not known	1	1	..	1	1	..	1				
Total	100	100	100	100	100	100	100				
Base: Informants who had been to surgery in previous 5 years (excluding housebound).											
	234	908	407	1353	638	226	3920				

Table 4.16 Ease of journey to doctor's by age, social class and sex

Journey to doctor's is:	16-44				45-64				65-74				75 and over			
	Non-manual		Manual		Non-manual		Manual		Non-manual		Manual		Non-manual		Manual	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Very easy	75	62	70	61	72	54	61	53	61	53	55	47	41	39	40	28
Fairly easy	22	35	27	33	26	40	34	38	32	38	42	39	41	39	40	38
Fairly difficult	1	2	1	4	1	4	4	6	7	5	2	10	11	15	15	15
Very difficult	1	1	—	—	—	—	1	2	—	3	2	3	6	7	5	12
Not known	2	1	1	1	—	—	—	1	—	2	—	1	—	—	—	6
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	362	400	533	613	239	286	316	379	80	93	134	148	32	56	40	50

cases the distance was less when there were branch surgeries.

How easy people found it to reach their doctors' surgeries, however, did not vary to the same extent as the distance. This, it seems, is because people, or the services they use, or both, to some extent adapt themselves to one another. Thus, for example, country dwellers are more likely than others to have the use of a car and to use it to visit their doctor. Distance, nevertheless, was an important influence on ease of access.

People's social and demographic characteristics affect the extent to which they can adapt themselves to their

circumstances, and how old they were, their sex and social class, together had a much greater effect on how easy they found it to visit their doctor than whether or not they either lived in the country or their doctor worked in a large group practice.

Elderly people in particular, whatever the distance to the surgery, were less likely to find the journey 'very easy' and more likely to find it 'fairly' or 'very difficult'. Elderly women found more difficulty than elderly men.

Reference

¹ Common Services Agency. *Annual Report, 1976.*

5 Access to the doctor at the surgery—the administrative arrangements

5.1 Introduction

The accessibility of doctors depends only partly on how easy it is for the patients to reach the surgeries. A doctor who holds only one surgery a week in his area, for example, even if it is within five minutes walk of most of his patients' homes, may be less accessible than another, more distant, doctor who holds surgeries twice a day every day. Not only surgery hours but also appointment systems, the period that people have to spend in the waiting room and the presence of a receptionist may all contribute to the accessibility or otherwise of the doctor, himself*.

The effects of appointment systems and receptionists are of particular interest because both have become increasingly common over the last decade or so. Cartwright and Anderson, for example, found that whilst 15% of the patients interviewed in a 1964 survey reported that their doctors operated appointment systems, a vastly greater proportion—75%—of those interviewed in 1977 said the same. Similarly, although the change is less dramatic, three-quarters of the patients' doctors surveyed in 1964 had a secretary or receptionist, but virtually all those included in the 1977 enquiry had one or the other¹.

In theory, these developments should increase the accessibility of doctors, in the first case at least by reducing the time people have to wait before seeing their doctor once they have reached the surgery, and in the second case by freeing doctors of some administrative burdens and so allowing them to devote more time and attention to their patients. Some of the questions we asked informants, however, allow that less optimistic views may be correct; namely that receptionists may act as barriers, or at least screens, between doctor and patient and that appointment systems may be daunting obstacles to some people.

Surgery hours are not known to have changed in recent years although there is a suggestion from a survey on another subject that both morning and evening, as opposed to afternoon, surgeries became a little more prevalent between 1970 and 1975². Whether or not this is so, the clustering of doctors into group practices might be expected to have extended surgery hours since four or five doctors, say, working together can presumably more easily arrange their duty rotas to cover

longer hours between them without fatigue, than a doctor working on his own.

5.2 Surgery hours

Information about surgery hours was obtained from the sample of people rather than from Family Practitioner Committees, but because people do not always know for how many days a week and during which hours their doctors hold surgeries, they were asked only what we supposed they were most likely to know: the times at which morning surgeries began, at which evening surgeries ended, and whether there was a Saturday surgery. Even so, 8% did not know the first, 17% the second and 17% the third. Altogether 22% of the informants did not know one or other of the two times. It should be said here that only the people who had visited their doctors within the preceding five years were asked the question, because, apart from the difficulty of remembering surgery hours over a longer period, it is quite possible that they will have changed.

According to the argument stated earlier, it is to be expected that the greater the number of doctors in the practice, the more extensive surgery hours will be. In fact as Table 5.1 shows, the larger the practice the earlier in the day surgeries were likely to start: 8% of patients using single-handed practices reported surgeries starting before 9 am, compared with 17% of those using practices of six or more doctors. On the other hand, this advantage—if it is one—of using larger practices was off-set at the close of the day, for it was people using the smaller practices who were most likely to report surgeries ending after 6.30 pm: 41% of the people attending single-handed practices gave closing times as late as this, but only 31% of the people using the largest practices. Nor was there any difference by size of practice in the proportions reporting that there was only one surgery a day.

It cannot therefore be concluded from the present findings that larger practices provide more extensive surgery hours than others. It is, however, possible that they cover more days of the week, and whilst we do not know this, there was evidence that the larger the practice used the more probable that a Saturday surgery was available, although differences were not great. The trend, such as it is, however, is largely due to the increasing proportion of people with practice size reporting special Saturday surgeries for urgent cases only or particular groups, like children, for it was those using the smaller practices who were most likely to say that an ordinary surgery was held on Saturdays.

* In 1976, 86% of general practitioners in England were males, and although the proportion of females has been increasing for some years it still seems reasonable to refer to a GP as 'he'. (Source of percentage—DHSS, *Health & Personal Social Services Statistics for England, 1977*.)

Table 5.1 Reported surgery hours by number of doctors in practice

	Single doctor	2-3 doctors	4-5 doctors	6 or more	Total
Weekday surgery hours:	%	%	%	%	%
Start before 9.0 am					
end before 6.0 pm	2	2	3	3	2
end 6.0-6.30 pm	3	4	6	6	5
end 6.30 or later	3	6	6	7	6
Start 9.0-9.30 am					
end before 6.0 pm	6	7	6	7	7
end 6.0-6.30 pm	18	19	18	19	18
end 6.30 or later	25	24	23	18	23
Start 9.30 am or later					
end before 6.0 pm	3	2	1	1	2
end 6.0-6.30 pm	5	4	2	2	4
end 6.30 or later	12	6	6	6	7
Only 1 surgery per day	6	6	6	5	6
Times not known	17	20	24	27	21
Total	100	100	100	100	100
Saturday surgeries:					
Ordinary surgery on Saturday	35	26	24	20	26
Urgent cases only/special groups (eg children)	19	34	36	42	33
Saturday surgery— status not known	3	3	3	3	3
No Saturday surgery	26	21	19	18	21
Informant did not know if Saturday surgery	16	15	18	17	17
Total	100	100	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years (excluding housebound)</i>	658	1692	1126	433	3920

Table 5.2 Reported surgery hours, by region and country

	North	Mid- lands	South East	South West	England	Wales	Scotland	Northern Ireland	Total UK
	%	%	%	%	%	%	%	%	%
Weekday surgery hours:									
Start before 9.0 am									
end before 6.0 pm	3	3	1	1	2	1	2	2	2
end 6.0-6.30 pm	6	7	4	4	6	3	3	—	5
end 6.30 or later	4	6	8	8	6	2	2	3	6
Start 9.0-9.30 am									
end before 6.0 pm	7	5	5	8	6	9	11	10	7
end 6.0-6.30 pm	22	18	15	16	18	21	21	14	18
end 6.30 or later	20	21	29	28	24	21	15	13	23
Start 9.30 am or later									
end before 6.0 pm	1	1	1	2	1	2	3	6	2
end 6.0-6.30 pm	3	2	4	1	3	6	7	14	4
end 6.30 or later	5	6	11	3	7	15	5	6	7
Only 1 surgery per day	5	6	3	7	5	9	7	25	6
Times not known	23	25	20	22	22	11	23	8	21
Total	100	100	100	100	100	100	100	100	100
Saturday surgeries:									
Ordinary surgery on Saturday	27	22	32	24	27	24	26	14	26
Urgent cases only/ special groups (eg children)	32	37	30	36	33	34	33	16	33
Saturday surgery— status not known	4	3	4	4	3	2	2	3	3
No Saturday surgery	20	22	18	20	20	22	22	57	21
Informant did not know if Saturday surgery	18	16	16	17	17	18	17	11	17
Total	100	100	100	100	100	100	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years (excluding housebound)</i>	973	841	972	490	3276	183	352	109	3920

There was no evidence of any noteworthy differences in surgery hours between those using health centres and others. Table 5.2 shows the variation in reported surgery hours between countries of the UK and regions of England. The most apparent deviation from the general uniformity is Northern Ireland where people in the small sample were much more likely than others to report that there was only one surgery a day and no Saturday surgery.

In all cases the conclusions are somewhat vitiated by the high proportion of people who did not know opening or closing times or both. The qualification applies particularly in the case of practice size, because, as can be seen from Table 5.1, the proportion of people who did not know increased with the number of doctors in the practice used, perhaps because the larger the practice the further it tended to be from people's homes (see Chapter 4).

The important question about surgery hours is how convenient people found them to be, and in fact over 90% said they were convenient and only 7% that they were inconvenient (Table 5.3). The proportion finding the times inconvenient varied somewhat with the reported surgery hours, and of course the most restricted hours were the most likely to be considered

inconvenient, and it was those experiencing them who were on the whole most likely to want additional surgery hours: for example 18% of the people having surgeries available to them which began after 9.30 am and ended before 6 pm wanted changes, compared with only 9% of those who used surgeries which began before 9 am and ended after 6.30 pm (Table 5.4). Overall 12% of the informants wanted surgery hours to be other than what they were.

Greater proportions of the elderly than of others found surgery hours very convenient, and it was the men below retirement age who were particularly likely to report them as inconvenient (Table 5.5). This is because it is mainly employment status which affects how convenient people find surgery hours to be (Table 5.6), although it is worth noting that even amongst the full-time employed only 10% said they were actually inconvenient. There were no systematic or notable differences between social classes whatever their employment status in their views of the convenience of surgery hours.

5.3 Appointment systems

Nearly three-quarters of the informants said the practices they used operated appointment systems. This included 8% who said the appointment system applied

Table 5.3 Convenience of surgery hours, by reported times of surgeries

Table 3.5 Convergence of surgery hours, by reported times of surgeries										
Surgery hours considered to be:	Times of surgeries									Total
	Begins before 9.0			Begins 9.0-9.30			Begins 9.30 or later			
	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	
	%	%	%	%	%	%	%	%	%	%
Very convenient	55	54	60	52	53	57	38	43	55	51
Fairly convenient	38	39	35	38	38	39	47	46	40	40
Fairly inconvenient	3	5	3	9	6	2	12	6	3	5
Very inconvenient	4	1	1	2	2	1	3	3	1	2
Can't say	—	1	1	—	1	1	—	1	—	2
Total	100	100	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding household)										
	81	196	222	261	722	900	60	140	266	3920*

*This total includes those informants who reported only 1 surgery per day, or who did not know surgery times.

Table 5.4 Additional surgery hours wanted, by reported surgery hours

Table 24.4. <i>Times of surgery in previous 5 years</i>											Total
Whether additional surgery hours wanted:	Times of surgeries										
	Begins before 9.0			Begins 9.0-9.30			Begins 9.30 or later				
	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later		
	%	%	%	%	%	%	%	%	%	%	
Yes	15	11	9	20	16	9	18	16	8	12	
No	85	89	91	80	84	91	82	84	92	88	
Total	100	100	100	100	100	100	100	100	100	100	
<i>Base: Informants who had been to surgery in previous 5 years (excluding household)</i>											
	81	196	222	261	722	900	60	140	266	3920*	

*This total includes those informants who reported only 1 surgery per day, or who did not know surgery times.

Table 5.5 Convenience of surgery hours, by age and sex

Surgery hours considered to be:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Very convenient	34	43	46	48	48	69	62	48
Fairly convenient	48	45	45	41	41	27	35	42
Fairly inconvenient	8	8	4	5	6	2	1	6
Very inconvenient	5	3	2	2	3	—	—	2
Can't say	4	1	3	4	2	3	1	2
Total	100	100	100	100	100	100	100	100
Base:	288	353	280	289	280	213	74	1777
Females	%	%	%	%	%	%	%	%
Very convenient	42	50	56	56	59	62	59	54
Fairly convenient	47	44	38	39	37	35	29	39
Fairly inconvenient	8	4	3	4	3	1	2	4
Very inconvenient	1	1	2	1	1	—	—	1
Can't say	2	1	2	1	—	2	9	2
Total	100	100	100	100	100	100	100	100
Base:	304	394	360	368	328	263	120	2137
Persons	%	%	%	%	%	%	%	%
Very convenient	38	47	52	52	54	65	60	51
Fairly convenient	48	44	41	40	39	31	31	40
Fairly inconvenient	8	6	3	4	4	1	2	4
Very inconvenient	3	2	2	1	2	—	—	2
Can't say	3	1	2	2	1	2	7	2
Total	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	592	746	640	657	608	476	194	3920

Table 5.6 Convenience of surgery hours by employment status

Surgery hours considered to be:	Full time employed	Part time employed	Not employed	Total
	%	%	%	%
Very convenient	44	56	59	51
Fairly convenient	44	40	36	40
Fairly inconvenient	7	3	2	4
Very inconvenient	3	1	—	2
Can't say	2	1	2	2
Total	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	1840	470	1558	3920

only to some surgery sessions so that patients had the option of either making an appointment or just turning up on the occasions when no appointment was necessary.

The proportions of people reporting an appointment system increased with the number of doctors in the practice used from 42% of those using single-handed practices to 94% of the people using practices of six or more doctors (Table 5.7). The likelihood of having a mixed system did not vary with the size of practice used.

Table 5.7 Use of appointment systems at practice attended, by number of doctors in practice

Informant attends practice with:	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Appointment system only	36	62	79	87	65
Appointment system for some surgeries	6	9	8	7	8
No appointment system	58	28	14	6	27
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	658	1692	1126	433	3920

A greater proportion of the people using practices in health centres than others said there was an appointment system (86% compared with 70%). This was largely because of differences amongst the people attached to the smaller practices (up to three doctors) of whom 75% of health centre users reported an appointment system compared with only 50% of non health centre users. For the people using the largest practices, however, appointment systems were no more likely to be reported for health centres than for elsewhere (Table 5.8).

It seems, therefore, that appointment systems are associated with other recent developments in general practice; namely the clustering of doctors into group practices and the establishment of health centres.

The use of practices with appointment systems varied little between the regions and the only notable difference between the countries of the UK was that a greater proportion of those in Wales reported no appointment system (Table 5.9).

People on the shortest lists and those in non-designated areas were rather less likely than others to say there was

an appointment system, but the differences were quite small (Tables 5.10 and 5.11).

Far more people preferred appointments than preferred open systems, 60% compared with 30%, but as Table 5.12 shows this is because in this respect most people prefer what they have, and it will be remembered that the great majority of informants used practices with appointment systems. Thus over three-quarters of the people using practices operating appointment systems preferred such a system, and conversely approaching three-quarters of those using practices without one, preferred none. It is unlikely that most people chose practices which offered the system they already liked best, because as will be shown in Chapter 8, the majority had been using the same practice for at least 10 years and many must have experienced a change from an open to appointment system during this period. Many of those who had registered more recently with their current practice, moreover, had selected it because it was the most convenient to get to or because it had

Table 5.11 Use of appointment system at practice attended, by whether in designated or non-designated area

Informant attends practice with:	Designated area	Non-designated area	Total
	%	%	%
Appointment system	69	63	64
Appointment system for some surgeries	7	8	8
No appointment system	22	27	26
Not known	2	2	2
Total	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years (excluding housebound)</i>			
	556	3366	3920

been recommended by someone they knew. Very few indeed mentioned the presence or absence of an appointment system as a factor in their choice. As will be shown shortly, however, there is suggestive evidence that at least some people exercised choice on this basis.

Although, in general, people preferred the system they

Table 5.8 Use of appointment system at practice attended, by number of doctors in practice and whether in a health centre or not

Informant attends practice with:	In health centre			Not in health centre			Total	
	Up to 3 doctors	4-5 doctors	6 or more	Up to 3 doctors	4-5 doctors	6 or more	In health centre	Not in health centre
	%	%	%	%	%	%	%	%
Appointment system	75	82	85	50	76	84	80	62
Appointment system for some surgeries	6	7	4	9	8	7	6	8
No appointment system	17	10	4	40	14	6	13	30
Not known	2	2	6	1	2	2	—	—
Total	100	100	100	100	100	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years (excluding housebound)</i>								
	378	279	78	1969	845	352	736	3174

Table 5.9 Use of appointment system at practice attended, by region and country

Informant attends practice with:	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Appointment system	67	66	57	73	65	49	67	71	64
Appointment system for some surgeries	6	7	10	9	8	14	7	2	8
No appointment system	26	25	31	17	26	37	24	27	26
Not known	1	2	2	2	2	—	2	1	2
Total	100	100	100	100	100	100	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years (excluding housebound)</i>									
	973	841	973	491	3278	183	352	109	3920

Table 5.10 Use of appointment system at practice attended, by average list size

Informant attends practice with:	Up to 1800	1801-2100	2101-2500	2501-3000	3000 or more	Total
	%	%	%	%	%	%
Appointment system	50	62	69	70	62	64
Appointment system for some surgeries	9	9	8	7	7	8
No appointment system	40	28	21	21	30	26
Not known	1	1	1	2	2	2
Total	100	100	100	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years (excluding housebound)</i>						
	436	578	1072	997	666	3920

were used to, it is possible that appointment systems were favoured more by some groups of people than by others.

The elderly, for example, might be expected to prefer the open systems to which they were earlier accustomed; but this did not seem to be the case. As Table 5.13 shows the elderly who were using practices with appointment systems were as likely as anyone else to prefer them, and although smaller proportions of the elderly than of younger people using practices without them favoured appointment systems, they were much more inclined to say they had no preference. There is therefore no evidence that the elderly were particularly prone to find appointment systems forbidding. There was however a social class difference such that it was those in the manual group who were most likely to opt for the system they had, whichever it was, especially if it was an open system, whilst people in the non-manual group were much more inclined to prefer their own doctor's system if it involved appointments than if it were open (Table 5.14). A rather greater proportion of the people with than without telephones preferred appointment

systems—64% compared with 53%. It is possible that the class difference in preference for an appointment system springs from difference in telephone ownership (see Table 2.14). But even amongst those with telephones 69% of the non-manual compared with 58% of the manual group favoured appointment systems.

It is, incidentally, the variation by social class in the use of practices with appointment systems which suggests that some people did choose practices because they operated a particular system. Only 18% of the people in Class I used practices with open systems, but about 30% of Classes IV and V. There was no comparable variation by age.

There is already evidence that people whose doctors run appointment systems spend less time in the waiting room than others¹, and the present survey provides further confirmation of this. For example, only 12% of the people who had made an appointment in the preceding year had had to wait about half an hour or more, compared with 32% of those using doctors with an open system (Table 5.15). But, not surprisingly,

Table 5.12 Informants' views on appointment system, by type of system operated at practice attended

Informant would prefer practice to have:	Present practice operated			Total
	Appt. system at all surgeries	Appt. system at some surgeries	No appt. system	
	%	%	%	%
Appointments system	77	60	17	60
Open system	16	23	71	31
No preference	6	9	10	7
Other answers (eg mixed system, more flexible system)	2	8	2	2
Total	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	2520	310	1028	3920

Table 5.13 Preference for appointment system, by age

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
(a) Uses practice with appointment system:								
Prefers:								
appointment system	72	75	80	77	79	77	78	77
open system	19	18	14	16	15	14	10	16
no preference	6	5	4	5	5	8	12	6
other answers	3	2	1	2	1	1	—	2
Total	100	100	100	100	100	100	100	100
Base: Informants using practices with appt systems who had been to surgery in previous 5 years	378	512	408	416	382	300	121	2520
(b) Uses practice with open or mixed system:								
Prefers:								
appointment system	28	34	31	29	24	19	9	27
open system	60	54	58	60	63	65	63	60
no preference	9	6	6	10	11	14	28	10
other answers	4	7	4	2	2	2	—	3
Total	100	100	100	100	100	100	100	100
Base: Informants using practices with open or mixed systems who had been to surgery in previous 5 years	208	223	222	233	213	170	66	1338

Table 5.14 Preference for appointment system, by social class

	Non-manual			Manual			Total
	I	II	IIIM	IIIM	IV	V	
	%	%	%	%	%	%	%
(a) Uses practice with appointment system							
Prefers:							
appointment system	85	82	81	75	71	69	77
open system	10	11	14	18	20	24	16
no preference	2	5	4	6	8	7	6
other answers	3	2	1	2	1	1	2
Total	100	100	100	100	100	100	100
Base: Informants using practices with appt systems who had been to surgery in previous 5 years	167	610	274	860	373	144	2520
(a) Uses practice with open or mixed system							
Prefers:							
appointment system	34	35	28	28	18	17	27
open system	48	50	60	59	70	76	60
no preference	7	11	10	10	8	6	10
other answers	11	4	2	3	3	1	3
Total	100	100	100	100	100	100	100
Base: Informants using practices with open or mixed systems who had been to surgery in previous 5 years	64	284	124	476	251	80	1338

people who had made appointments were less tolerant of long waits. Thus, for example, nearly three-quarters of the people who had had to wait at least about three-quarters of an hour after making an appointment regarded this as unreasonable compared with less than half the people who had waited just as long without an appointment.

Amongst the people using practices with appointment systems the proportions saying they went in to see the doctor on time at their last visit declined slightly with increasing practice size and was a little lower for those using health centres than for others.

There was also some indication that the people who used practices with open systems had to wait longer the larger the practice and if they used health centres than if they used other types of practice. Although the

variations are very small, it is clear that in this respect practices of the more 'modern' kind were at least no more efficient than others from the patients' point of view.

Although appointment systems mean patients have to spend less time than otherwise in the doctor's waiting room, they entail arranging to see the doctor beforehand and waiting until the appointed time to see him. If the waiting period were several days or a week or so this would certainly be a disadvantage for people worried about their health.

In fact over a third of the people who made an appointment for their last visit during the past year had been able to arrange to see the doctor the same day and as many again had fixed an appointment for the following day. Altogether over 90% had been able to

Table 5.15 Time spent in waiting room before seeing doctor, by whether made an appointment and number of doctors in practice

Time spent in waiting room	Had made appointment					Had not made appointment					Total
	Single doctor	2-3 doctors	4-5 doctors	6 or more	All making appt	Single doctor	2-3 doctors	4-5 doctors	6 or more	All not making appt	
	%	%	%	%	%	%	%	%	%	%	%
Went in to see doctor straight away/ on time	37	36	32	30	34	7	7	9	8	7	25
Waited about:											
5 minutes	16	14	16	12	15	17	9	8	12	12	14
10 minutes	16	15	17	18	16	19	13	13	17	15	16
15 minutes	9	9	10	13	10	15	16	15	9	15	12
20 minutes	8	7	6	7	7	15	14	16	3	14	9
30 minutes	4	6	7	7	6	13	15	14	19	14	9
45 minutes	2	4	3	4	4	6	9	7	11	8	5
One hr or more	1	3	2	3	2	5	11	14	12	10	5
Can't remember	6	5	6	5	5	3	5	4	9	4	5
Total	100	100	100	100	100	100	100	100	100	100	100
Base: Informants who had visited doctor in preceding year	190	802	692	296	1982	314	488	166	38	1010	2991

Table 5.16 Number of days waited for appointment by number of doctors in practice

Appointment arranged for:	Single doctor	2-3 doctors	4-5 doctors	6 or more	All group practices		Total
					Wanted particular doctor	Did not mind which doctor	
	%	%	%	%	%	%	%
Same day	46	35	35	37	29	45	36
Next day	34	36	36	31	36	34	35
2-3 days later	16	22	21	21	24	16	21
4-5 days later	3	4	4	6	6	2	4
More than 5 days later	1	3	4	4	5	2	4
Can't remember	—	..	1	1	..	1	..
Total	100	100	100	100	100	100	100
<i>Base: Informants who made appt for last consultation within previous 12 months</i>							
	162	676	581	248	902	639	1669

Table 5.17 Number of days waited for appointment, by average list size

Appointment arranged for:	Up to 1800	1801-2100	2101-2500	2501-3000	3000 or more	Total
	%	%	%	%	%	%
Same day	40	36	38	34	34	36
Next day	30	34	34	38	36	35
2-3 days later	22	20	19	20	23	21
4-5 days later	5	6	5	4	3	4
More than 5 days later	3	3	4	3	4	4
Can't remember	—	1	..	1	..	..
Total	100	100	100	100	100	100
<i>Base: Informants who made appt for last consultation within previous 12 months</i>						
	152	244	482	480	260	1669

see the doctor within three days of making the appointment and only 4% had had to wait more than five days. Moreover amongst the people who had initiated the visit themselves rather than returned at their doctor's request, only 2% had had to wait so long.

People who used group practices were rather less likely than others to have seen the doctor on the day the appointment was made (Table 5.16) but this was because over half of them had wanted to see a particular doctor in the group. The people who had been willing to see any doctor available were just as likely to have been given an appointment for the same day as those who used single-handed practices. People using health centres were as likely as others to get an appointment for the same day and no more likely to have a lengthy wait.

People on larger lists were a little less likely to be seen the same day and those in designated areas were more liable to have to wait until the next or following two or three days than others (Tables 5.17 and 5.18).

It is perhaps the people who were anxious to see the doctor as soon as possible who are of most interest, although it may be that people's impatience is conditioned by their experience of what is 'as soon as possible'. Approaching half of this group (45%) had been given an appointment for the same day (compared with 36% of all the people who had made an appointment) and nearly 80% for the same or following day. The variations in the waiting time with the practice characteristics were by and large the same as for all appointments, whether required quickly or not.

It is worth noting that although only 7% of the people who had made an appointment in the preceding year had had to wait longer than three days for an appointment, 15% of all the people whose doctors operated appointment systems said it was difficult to get an appointment.

Table 5.18 Number of days waited for appointment, by whether in a designated or non-designated area

Appointment arranged for:	Designated area	Non-designated area	Total
	%	%	%
Same day	28	38	36
Next day	40	34	35
2-3 days later	24	20	21
4-5 days later	4	4	4
More than 5 days later	3	4	4
Can't remember	..	1	..
Total	100	100	100
<i>Base: Informants who made appt for last consultation within previous 12 months</i>			
	232	1436	1669

5.4 Receptionists

The vast majority—over 90%—of informants said that their doctor had a receptionist. The proportion reporting this varied very little by country of the UK or region of England, and although people using some types of practice were more likely than others to say there was a receptionist, the great majority said there was one whatever the other features of the practice.

Table 5.19 Presence of receptionist, by number of doctors in practice

Whether practice has receptionist	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Yes	79	95	98	99	94
No	20	4	2	1	6
Don't know	1	..	..	..	1
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	658	1692	1126	433	3932

Table 5.20 Presence of receptionist, by whether practice in a health centre or not

Whether practice has receptionist	In health centre	Not in health centre	Total
	%	%	%
Yes	98	92	94
No	2	7	6
Don't know	1	1	1
Total	100	100	100
Base: Informants who had been to surgery in previous 5 years	736	3174	3932

Table 5.21 Presence of receptionist, by average list size

Whether practice has receptionist	Up to 1800	1801-2100	2101-2500	2501-3000	3000 or more	Total
	%	%	%	%	%	%
Yes	85	92	95	95	95	94
No	15	8	4	4	5	6
Don't know	..	1	..	1	1	1
Total	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	436	578	1072	997	666	3932

Table 5.22 Presence of receptionist, by whether in a designated or non-designated area

Whether practice has receptionist	Designated area	Non-designated area	Total
	%	%	%
Yes	97	93	94
No	2	6	6
Don't know	1	..	1
Total	100	100	100
Base: Informants who had been to surgery in previous 5 years	559	3373	3932

The variation which did occur was as might be expected: those using group practices and health centres were more likely than others to report a receptionist, but the difference in the latter case was very slight (Tables 5.19 and 5.20). In addition, rather greater proportions of people on the larger lists and in designated areas, than others, said there was a receptionist, but again the differences were not large (Tables 5.21 and 5.22).

Over three-quarters of the people using practices with a receptionist held favourable views of the person doing the job and only just over 10% held unfavourable views. The views related to the receptionist as a barrier between patient and doctor and were composed from the following four items:

she tries to be as helpful as possible when you want to see the doctor;

she only arranges for you to see the doctor when *she* feels it necessary;

she makes you feel you shouldn't be bothering the doctor;

she sometimes makes it difficult for you to see the doctor when you want to.

Those who agreed with a favourable statement or disagreed with an unfavourable one were given a score of 1, and those at the other extreme a score of 3. People

who neither agreed nor disagreed were scored 2. The results were then summed so that, at one end of the scale, a score of 4 was taken as very favourable, and at the other, a score of 11-12 as very unfavourable, whilst a score of 7-8 was taken to show mixed feelings.

It might be expected that some groups would be less favourably inclined towards receptionists than others, and that in particular, the elderly who grew to maturity before receptionists became the rule, and people from the manual group who are less appreciative than others of at least some kinds of organisational formality, would be most likely to see receptionists as a barrier—a dragon before the doctor's door. In fact, there was virtually no variation by social class in the proportion holding favourable views of the receptionist (Table 5.23), and the elderly were actually more prone than younger people to appreciate her: for example, less than half the 16-24 year old group but over two-thirds of the over 75s held very favourable views of the receptionist (Table 5.24).

Whilst over three-quarters of the informants regarded receptionists as no hindrance to access to the doctor, an even greater proportion (84%) believed that she helped to make the surgery run more efficiently than it otherwise might.

Table 5.23 Attitude towards receptionist, by social class

Attitude towards receptionist	Non-manual			Manual			Total
	I	II	IIINM	IIIM	IV	V	
	%	%	%	%	%	%	%
Very favourable	60	64	65	61	62	65	63
Favourable	22	18	14	19	20	14	18
Mixed	9	7	10	8	7	8	18
Unfavourable	5	6	6	6	5	8	6
Very unfavourable	4	5	5	6	6	5	5
Total	100	100	100	100	100	100	100
Base: Informants whose practice had receptionist and who had been to surgery in previous 5 years	214	825	363	1222	562	194	3510

Table 5.24 Attitude towards receptionist, by age

Attitude towards receptionist	16-24	25-34	35-44	45-54	55-64	65-74	75 or over	Total
	%	%	%	%	%	%	%	
Very favourable	52	53	60	64	71	76	77	63
Favourable	22	19	18	18	17	15	15	18
Mixed	12	9	9	7	5	6	4	8
Unfavourable	7	9	6	6	4	2	3	6
Very unfavourable	6	9	7	4	3	2	1	5
Total	100	100	100	100	100	100	100	100
Base: Informants whose practice had receptionist and who had been to surgery in previous 5 years	510	690	583	608	527	419	167	3510

Table 5.25 Views on whether receptionist should ask patient why he/she wants to see doctor, by whether receptionist enquires

Informant thinks receptionist:	Receptionist asks patient why he/she wants to see doctor				Total
	Never	On all or most occasions	Sometimes	Don't know	
	%	%	%	%	%
Should ask	8	27	16	24	14
Shouldn't ask	63	46	47	42	56
Doesn't mind	29	27	37	35	30
Total	100	100	100	100	100
Base: As previous table but whose practice also had an appointment system	1605	96	546	482	2762

The way in which the receptionist may both increase efficiency and inhibit consultations is by asking people trying to make appointments why they want to see the doctor. Over half (58%) of the people whose doctors ran appointment systems said the receptionist never enquired, and 20% said she always or usually did so. People's views on whether this was the right thing for her to do again reflected to some extent what they were used to: less than 10% of the people who were never asked thought they should be, compared with over a quarter of those who were usually asked. It is notable, however, that whatever usually happened, more people thought the receptionist should not ask why they wanted to see the doctor, than thought she should, although many did not mind (Table 5.25).

5.5 Summary

There is no evidence that the administrative features of

practices considered in this chapter are a widespread hindrance to people's access to their doctors. Most people are content with the surgery hours, and with the appointment or open system provided by the practice they use, and most do not regard receptionists as barriers between themselves and their doctors. Between 10% and just over 15% of the sample as a whole were dissatisfied in any way with what was available at their doctor's practice.

References

- 1 Ann Cartwright and Robert Anderson. *Patients and their doctors in 1977*. Institute for Social Studies in Medical Care, 1978.
- 2 Margaret Bone. *The family planning services: changes and effects*. HMSO. 1978. Table 3.4, p 15.
- 3 Ann Cartwright and Robert Anderson. *General Practice revisited*. Tavistock Publications, 1981.

6 People's views of their doctor and his surgery

6.1 Introduction

In addition to the proximity of the doctor's practice and the potential obstacles to be overcome before coming face to face with the doctor, people's perception of the doctor himself and of his surgery may well influence their inclination to consult him when they are unwell. Although such perceptions will be partly idiosyncratic, they are also likely to be influenced by objective and commonly occurring circumstances; for example, people using group practices have an opportunity not given to those using lone GPs to choose a doctor they find suited to their taste, whilst, in the case of the surgery, it might be expected that health centres having been recently established will more often than other practice premises be light, airy, clean and modern.

We cannot take into account the way individual differences modify the effects of practice organisation on people's views of their doctor and his surgery, but it is possible to take some account of the relevant differences between some sub-groups, specifically those for age, sex and social class, although as was shown in Chapter 3, none of the sub-groups is more likely than others to patronise particular types of practice.

6.2 People's views of their doctor

Although people's views of their doctor's professional competence may influence how often they consult him, the most pertinent view to an enquiry concerned with accessibility appeared to be that of his 'approachability'. Accordingly informants were asked whether their doctor was or was not like the following:

- He's the kind of person you can talk to;
- He takes care to explain things as fully as possible;
- He's always willing to sit and listen to you;
- He's someone you could go to for help and advice;
- He always seems very friendly.

(In retrospect it seems unfortunate that all the statements were positive, so that people with an inclination to reply 'yes' will spuriously increase the proportion with favourable views.)

Those who replied 'yes' to any statement were scored 1, and those replying 'no' as 3, whilst people who said they did not know were scored 2. The scores were then summed to form a scale so that those with a total score of 5 or less were considered to hold very favourable views, and at the other end of the scale, those with a score of 15 to have very unfavourable views.

According to the measure used, three-quarters of the

sample had a favourable view of their doctor's approachability, including rather over half who had a very favourable view. There were 16% who held unfavourable views.

6.3 Age, sex and social class

The proportions holding very favourable views increased with age and conversely the proportions having very unfavourable views declined (Table 6.1). Women were slightly more likely to hold very favourable views than men, mainly because of a difference below the age of 45 to 54.

Views were also related to social class so that those in the manual group were rather more likely than others to regard their doctor as very approachable (Table 6.2).

It is possible, however, that the relationships with both age and social class may be at least partly due to the greater propensity of some groups, for example the elderly, compared with others to reply 'yes' when presented with statements to which they have to reply 'yes' or 'no'.

6.4 Practice type

Contrary to expectations, there was little difference between people using different practice sizes in the proportions holding favourable or unfavourable views, although the differences that were found were in the anticipated direction, so that 18% of the people using single-handed practices had unfavourable views compared with 13% of those using practices of four or more doctors (Table 6.3). There was virtually no difference between those using health centres and others (Table 6.4).

This suggests that whilst modern forms of practice organisation have done little if anything to improve understanding between doctor and patient, neither have they worsened it by making it more impersonal.

It might be expected that patients on the longer lists would find their doctors less approachable than others do, since doctors with unusually large numbers of patients are likely to be under greater pressure than other doctors. But, although people on the longest lists—3000 or more patients—were the most inclined to hold unfavourable views of their doctor's approachability, the difference was not great, and the proportions holding favourable or unfavourable views did not vary systematically with list size (Table 6.5). Neither was there any difference between people using practices in designated areas and others.

Table 6.1 Approachability of doctor, by age and sex

Informant's view of doctor's approachability	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Very favourable	39	41	54	57	65	72	72	54
Favourable	24	24	24	19	18	15	20	21
Mixed	11	9	9	10	5	7	3	8
Unfavourable	22	22	10	12	11	6	5	14
Very unfavourable	4	4	3	2	2	—	—	2
Total	100	100	100	100	100	100	100	100
Base:	315	380	302	320	305	239	90	1954
Females								
Very favourable	46	50	60	53	63	70	70	58
Favourable	22	22	18	20	19	16	12	19
Mixed	12	10	6	10	7	4	8	8
Unfavourable	16	14	11	13	8	7	9	11
Very unfavourable	3	4	4	4	3	2	2	3
Total	100	100	100	100	100	100	100	100
Base:	316	394	363	391	350	292	169	2280
Persons								
Very favourable	43	46	58	55	64	71	71	56
Favourable	23	23	21	20	18	16	15	20
Mixed	11	10	8	10	6	6	6	8
Unfavourable	19	18	10	13	10	6	8	13
Very unfavourable	4	4	4	3	2	1	1	3
Total	100	100	100	100	100	100	100	100
Base: All NHS registered informants who had ever had contact with a doctor at the practice they attend	631	774	666	710	656	532	259	4234

Table 6.2 Approachability of doctor, by social class

Informant's view of doctor's approachability	Non-manual			Manual			Total
	I	II	IIINM	IIIM	IV	V	
	%	%	%	%	%	%	
Very favourable	50	53	57	55	62	60	56
Favourable	23	21	20	21	17	17	20
Mixed	10	8	8	9	6	10	8
Unfavourable	15	13	12	13	12	10	13
Very unfavourable	2	4	2	2	3	3	3
Total	100	100	100	100	100	100	100
Base: (See Table 6.1 for description)	250	976	433	1446	700	249	4234

Table 6.3 Approachability of doctor, by number of doctors in practice

Informant's view of doctor's approachability	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Very favourable	55	56	57	58	56
Favourable	19	18	23	19	20
Mixed	7	9	8	9	8
Unfavourable	15	14	10	11	13
Very unfavourable	3	3	3	2	3
Total	100	100	100	100	100
Base: (See Table 6.1 for description)	720	1822	1214	461	4234

Table 6.4 Approachability of doctor, by whether practice in a health centre or not

Informant's view of doctor's approachability	In health centre	Not in health centre	Total
	%	%	%
Very favourable	56	57	56
Favourable	22	19	20
Mixed	8	8	8
Unfavourable	12	13	13
Very unfavourable	3	3	3
Total	100	100	100
Base: (See Table 6.1 for description)	791	3412	4234

6.5 People's views of their doctor's surgery

Although the appearance and 'feeling' of the surgery may be less important to people than how they perceive the doctor, these features may nevertheless attract or repel people to some extent, and indeed contribute to their perception of the doctor himself. The prospect of visiting a doctor who sits in a small, dark surgery in which piles of paper spill from shelves and cover an undusted examination couch may deter some who, feeling equally unwell, would be prepared to visit the

Table 6.5 Approachability of doctor, by average list size of practice attended

Informants' view of doctor's approachability	Up to 1800	1801-2100	2101-2500	2501-3000	3000 or more	Total
	%	%	%	%	%	%
Very favourable	58	58	60	54	51	56
Favourable	20	18	20	21	18	20
Mixed	8	7	7	10	10	8
Unfavourable	11	14	10	12	17	13
Very unfavourable	3	3	2	3	4	3
Total	100	100	100	100	100	100
Base: (See Table 6.1 for description)	476	626	1148	1076	716	4234

same doctor if he worked in a light, clean and tidy surgery, surrounded by shining equipment.

Four aspects of people's view of the surgery were considered in the survey: firstly, whether they saw it as welcoming, friendly and so forth; secondly, whether it was regarded as efficient and organised; thirdly, whether it was seen as tidy and clean; and lastly, its modernity and spaciousness. The way in which these aspects were derived from question 51 of the questionnaire and how they were scored is described in detail in the annex to this chapter. It is only necessary to say here that views on each aspect were obtained from informants' assessments of whether their doctor's surgery was more like one descriptive word, such as 'welcoming' or more like its opposite—here 'unwelcoming'—and that each aspect was composed of two or more pairs of words of this kind.

As implied in the introduction to this chapter, it was expected that the more recently developed types of practice would more commonly than the traditional forms be seen as modern, efficient and possibly tidy. On the other hand, it could be that they are less likely to be perceived as welcoming and friendly.

As far as the number of doctors in the practice is concerned these expectations were only partly borne out and to a very limited extent indeed. The proportions of people considering their doctor's surgery to be tidy and modern increased slightly with practice size, although not regularly and consistently, whilst the proportion finding it welcoming declined a little. On the other hand there was no variation in the proportions who saw the surgery as being efficient (Tables 6.6-6.9).

Table 6.6 Informants' view of the tidiness/cleanliness of their doctor's surgery by number of doctors in practice

Surgery seen as:	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Very tidy	72 } 91	69 } 91	71 } 93	69 } 94	70
Tidy	19	22	22	25	22
Mixed	7	7	6	6	6
Untidy	2	1	1	..	1
Very untidy	1	..	..	..	..
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	660	1698	1127	436	3932

Table 6.7 Informants' view of the modernity/spaciousness of their doctor's surgery, by number of doctors in practice

Surgery seen as:	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Very modern	9 } 25	11 } 30	14 } 37	12 } 34	12
Modern	16	19	23	22	20
Mixed	32	31	34	34	32
Old fashioned	28	24	20	22	23
Very old fashioned	15	15	10	10	13
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	660	1698	1127	436	3932

Table 6.8 Informants' view of welcoming/cheerfulness of their doctor's surgery, by number of doctors in practice

Surgery seen as:	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Very welcoming	18 } 42	16 } 40	15 } 41	15 } 37	16
Welcoming	24	24	26	22	24
Mixed	34	35	34	39	35
Unwelcoming	18	20	21	20	20
Very unwelcoming	6	5	4	4	5
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	660	1698	1127	436	3932

Table 6.9 Informants' view of the efficiency of their doctor's surgery, by number of doctors in practice

Surgery seen as:	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Highly efficient	51 } 83	50 } 82	52 } 84	52 } 82	51
Efficient	32	32	32	30	32
Mixed	14	13	12	14	13
Inefficient	2	3	3	3	3
Very inefficient	1	1	1	1	1
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	660	1698	1127	436	3932

Table 6.10 Informants' view of the modernity/spaciousness of their doctor's surgery, by whether in a health centre or not

Surgery seen as:	In health centre	Not in health centre	Total
	%	%	%
Very modern	24 } 58	9 } 25	12
Modern	34	16	20
Mixed	31	33	32
Old fashioned	9	27	23
Very old fashioned	2	16	13
Total	100	100	100
Base: Informants who had been to surgery in previous 5 years	736	3184	3932

Table 6.11 Informants' view of the tidiness/cleanliness of their doctor's surgery, by whether in a health centre or not

Surgery seen as:	In health centre	Not in health centre	Total
	%	%	%
Very tidy	81 } 96	67 } 91	70
Tidy	15	24	22
Mixed	3	7	6
Untidy	..	1	1
Very untidy	..	..	..
Total	100	100	100
Base: Informants who had been to surgery in previous 5 years	736	3184	3932

Table 6.12 Informants' view of the efficiency of their doctor's surgery, by whether in a health centre or not

Surgery seen as:	In health centre	Not in health centre	Total
	%	%	%
Highly efficient	58 } 88	50 } 82	51
Efficient	30	32	32
Mixed	9	14	13
Inefficient	2	3	3
Very inefficient	1	1	1
Total	100	100	100
Base: Informants who had been to surgery in previous 5 years	736	3184	3932

The differences between people using health centres and others were more consistent and, for one aspect, marked; more than half the former considered the surgery to be modern, compared with only a quarter of those not using health centres (Table 6.10). The differences between the proportions who saw the surgery as tidy or efficient were smaller, although in the expected direction. However the differences in the proportions regarding the surgeries as very tidy or very efficient were rather greater (Tables 6.11 and 6.12). There was also a very slight difference between the two groups in their propensity to view the surgery as

Table 6.13 Informants' view of the welcoming/cheerfulness of their doctor's surgery, by whether in a health centre or not

Surgery seen as:	In health centre	Not in health centre	Total
	%	%	%
Very welcoming	18 } 43	16 } 40	16
Welcoming	25	24	24
Mixed	36	35	35
Unwelcoming	18	20	20
Very unwelcoming	3	5	5
Total	100	100	100
Base: Informants who had been to surgery in previous 5 years	736	3184	3932

welcoming and so forth, but this was not as expected, for it was those who used health centres who were the most likely to see the surgery in this way (Table 6.13).

People's perceptions of their doctor's approachability may depend as much on the patient, or at least on the individual relationships between particular patients and particular doctors, as on what doctors are 'really' like. On the other hand it is to be expected that people's opinions of the surgery will be influenced by more objective factors, for example, whether the surgery really is tidy (although people's judgement of what is or is not tidy will vary somewhat). It is therefore rather disconcerting to find that views of the surgery vary with age. This is perhaps not surprising in the case of 'modernity' (although this aspect comprehended spaciousness, and uncrowdedness, as well) because what may appear modern to the elderly may seem old fashioned to the young; and the findings that whilst only 6% of 16-24 year olds, but 20% of those aged 75 or more thought the surgery very modern can be interpreted in this way (Table 6.14). However one cannot so readily explain the evidence that 6% of the youngest group compared with 37% of the oldest found the surgery very welcoming and that the elderly were much more likely than the young to see it as efficient, and more likely to regard it as tidy (Tables 6.15-17). There are, however, a number of possibilities, none of which can be confirmed by the present survey. Firstly, the elderly may be generally more favourably inclined than younger people towards everything about their doctor's practice, perhaps because they consult more frequently (see next chapter) and are more familiar with and dependant on their doctors. Secondly, older people may be making comparisons with the past, when possibly surgeries were less efficient, tidy and so on than today.

Table 6.14 Informants' view of the modernity/spaciousness of their doctor's surgery, by age

Surgery seen as:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Very modern	6	6	11	11	18	17	20	12
Modern	13	17	21	21	22	25	23	20
Mixed	34	32	30	35	29	34	35	32
Old fashioned	29	28	22	23	21	18	16	23
Very old fashioned	18	17	16	10	11	7	6	13
Total	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	594	746	640	658	608	481	200	3932

Table 6.15 Informants' view of the welcoming/cheerfulness of their doctor's surgery, by age

Surgery seen as:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Very welcoming	6	7	11	16	23	32	37	16
Welcoming	18	21	25	24	29	26	28	24
Mixed	40	40	36	36	30	29	27	35
Unwelcoming	27	26	22	20	16	10	8	20
Very unwelcoming	8	7	6	5	2	2	1	5
Total	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	594	746	640	658	608	481	200	3932

Table 6.16 Informants' view of the efficiency of their doctor's surgery, by age

Surgery seen as:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Highly efficient	36	37	48	54	63	69	70	51
Efficient	40	38	33	30	26	25	24	32
Mixed	18	17	16	13	9	5	6	13
Inefficient	5	5	3	2	2	1	..	3
Very inefficient	2	2	1	1	..	..	..	1
Total	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	594	746	640	658	608	481	200	3932

Table 6.17 Informants' view of the tidiness/cleanliness of their doctor's surgery, by age

Surgery seen as:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Very tidy	60	59	68	73	78	82	80	70
Tidy	30	29	22	20	17	14	16	22
Mixed	8	10	8	6	3	3	4	6
Untidy	1	1	1	1	1	..	1	1
Very untidy	..	1	1	1	..	..	..	..
Total	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years	594	746	640	658	608	481	200	3932

Lastly, the difference may, as was suggested in the case of the doctor's perceived approachability, be due to the form of the question: the favourable pole of each dimension appeared first and it may have been easiest for those lacking energy or concentration to agree with the first (favourable) rather than the second (unfavourable) word shown.

6.6 Summary and discussion

Most people found their doctor approachable, in that they agreed, for example, that he was easy to talk to and explained things as fully as possible. The proportions who thought otherwise varied very little with the type of practice used, but rather more with informant's social class and very much more with their age. This suggests

that doctor-patient relationships cannot easily, if at all, be influenced by the organisation of practices, but that they depend to a considerable extent on the characteristics of patients. Whether they depend equally on the characteristics of doctors, including their training, cannot be determined from the present enquiry.

We supposed before examining the results that people's opinions of their doctor's surgeries would be more closely related to the type of practice they used than their views of the doctor, on the grounds that some kinds of practice would be more likely than others to have modern purpose-built surgeries. This proved to be true in the case of health centre users compared with other people; the former, of course, being the most

likely to regard their doctor's surgery as modern, very tidy and efficient. But, although greater proportions of people using the larger practices of four or more doctors, than others saw them as modern and tidy the difference particularly in the latter case was small and no greater proportion considered them to be efficient. In general, moreover, people's views of the surgery varied much more with their age than with the type of practice used. On the present evidence therefore it seems that people's characteristics influence their perception of the surgery, as of the doctor, to a greater extent than the type of practice they use. We have, however, no objective assessment of what the surgeries were actually like.

Finally, it should be recalled, that in retrospect we have reservations about the form of the questions about both the doctor's approachability and his surgery. If it is considered that patients' unfavourable views of either may deter them from consulting when they should, then further, more extensive and differently designed research in this area is necessary.

Reference

- ¹ McQuitty, L. L. Elementary linkage analysis. *Educ. Psychol. Measurement*, 17, 1957.

Annex: Measurement of informants' perceptions of the surgery

Informants were presented with 12 pairs of adjectives, of which the second of each pair was the opposite of the first, in the following form:

welcoming . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . unwelcoming

Informants were asked to think of their doctor's surgery and to ring one of the numbers between each pair of words according to whether they thought it was more or less (in the above example) welcoming or unwelcoming. (See also Q51 of interview schedule at Appendix C.)

A correlation matrix was produced from the responses and aspects of informants' perceptions of the surgery grouped according to McQuitty's elementary linkage method¹. This technique has the effect of identifying clusters of variables which are relatively highly inter-correlated. In the present case the clusters formed were as follows:

Tidy, clean	(TIDY)
Efficient, organised	(EFFICIENT)
Cheerful, friendly, welcoming, homely	(WELCOMING)
Spacious, uncrowded, modern, comfortable	(MODERN)

The groups are derived from the correlation matrix by a simple systematic procedure, modified by judgement where a particular dimension could equally well belong

to more than one group. For example, 'comfortable-uncomfortable' fitted as well into the 'welcoming' etc as into the 'modern' etc group to which it has actually been attached.

After the clusters of correlated variables had been formed in this way, informants were assigned a score on each cluster by summing their raw scores on each of the dimensions which made up that cluster. Thus someone who had ringed 1 for welcoming and the same for cheerful, friendly and homely received a score of 4 and was classified as regarding the surgery as very welcoming. At the other extreme, someone who had ringed 5 on each of welcoming, cheerful, friendly and homely was given a score of 20 and classed as regarding the surgery as very unwelcoming.

The proportions of the sample in the extreme groups (that is, those in the 'very welcoming', 'highly efficient' etc or 'very unwelcoming', 'very inefficient' etc categories) depend partly on how closely all the dimensions in the cluster concerned are inter-correlated, which in turn depends on the dimensions included in the original list. Thus the fact that there was a higher proportion of people classed as seeing the surgery as 'very welcoming' than as 'very modern' is at least partly because the dimensions included in the 'welcoming' group happened to be more closely related to one another than those in the 'modern' group. It does not necessarily mean that more people found their doctors' surgeries welcoming than found them to be modern.

7 Accessibility and the frequency of consultations

7.1 Introduction

As suggested at the beginning of Chapter 3, the crucial but probably unanswerable question about the varying accessibility of general practitioners is whether it results in a varying prevalence of ill health amongst patients, because some people are deterred from consulting their doctors when they should. Although the question could not be tackled directly, it is possible to show the extent to which the frequency of consultations was influenced by the accessibility and kind of practices people used. Unfortunately, from the point of view of inferring obstacles to necessary consultations, it can also be argued that particular forms of practice administration reduce the number of *unnecessary* consultations. In fact, there has been some evidence over the last 10 years or so that practices which are highly organised have lower than average consultation rates¹.

7.2 The measure used

The measure of consultation behaviour used was the number of times the informants said they had consulted for themselves any doctor from the practice used, either at home or the surgery, during the 12 months preceding the survey. Clearly this measure is subject to inaccuracy: it is unlikely that all the informants correctly recalled the number of times they had consulted their doctor over such a long period, and it was not possible to check their reports with GP records.

There is no very good way of validating the data from the present survey by comparison with that from other enquiries because of differences in methods and definitions. Figures from the General Household Survey (GHS) have a better claim to validity than our own, because they are based on reported consultations during two weeks preceding interview (interviews being conducted throughout the year) and this places less strain on informants' memories. The GHS figures, however, include telephone consultations, which ours do not. In addition the appropriate annual figure available from GHS is the mean number of consultations per patient, but no accurate mean can be produced in the present case because the numbers of consultations were recorded in precoded groups.*

* The 1970/71 National Morbidity Survey (NMS) is another obvious source of comparison, but its results differ somewhat from those of GHS. The reasons for the difference, which are considered in the 1972 GHS report (pp 208-210), suggest that a similar difference should occur between NMS and the results of the present survey—that is, the frequency of consultations in the latter will be higher than shown by NMS. This appears to be the case, mainly because the proportions of patients reporting no consultations were lower in the present survey.

Although it is not possible to check the absolute frequency of reported consultations with other sources, the fact that, as will be shown in the following Section, frequency is related to key patient characteristics in the same way as has been found by other enquiries promotes some confidence in their validity.

7.3 Relationships between frequency of consultation and patient characteristics

It is important to show the relationships between frequency of consultations and patient characteristics not only to lend support to our figures but also because it indicates the factors which have to be taken into account when relating consultation behaviour to the kind of practice used. Thus, if one age group was more likely than others to use health centres and also particularly liable to consult frequently, a disproportionate number of consultations by people attached to health centres would be explicable in terms of the age composition of those people. In fact it was shown in Chapter 3 that there were no differences in the age, sex or social class composition of groups using different types of practice but more subtle relationships between patients' socio-demographic characteristics, type of practice and frequency of consultation may be involved.

In what follows we shall point out the main features of the relationships between age, sex, social class and health status on the one hand, and consultation rates on the other, but omit detailed discussion since they have been described in other studies.

Table 7.1 shows that, as has usually been found, females had consulted more often than males at all ages, and that frequent consultations (10 or more) were most common amongst people aged over 64. Amongst males the increase with age in the proportion consulting 10 or more times was quite steady, but amongst females there was a decline for groups aged 35-54. As other work has demonstrated the higher frequency of consultation by women than men occurs partly because women consult rather more than men for many conditions and partly because they consult much more frequently for certain conditions such as diseases of the urino-genital system, mental disorders, obesity, for contraceptive advice and, of course, uniquely for pregnancy and childbirth.²

The frequency of consultations was related to social class, so that the unskilled were most, and professionals, least likely to have consulted 10 or more times. Conversely, those who had not consulted at all were most prevalent in the professional group and least so amongst the unskilled (Table 7.2). This evidence

Table 7.1 Number of consultations during previous year with GPs at practice attended, by age and sex of informant

Informant consulted GP:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Not at all	34	33	38	40	31	32	25	34
Once only	25	24	20	20	20	16	17	21
2-3 times	26	25	24	22	22	25	21	24
4-5 times	7	9	8	6	6	8	10	8
6-10 times	6	5	6	5	12	9	11	7
More than 10 times	2	4	3	7	8	9	15	6
Total	100	100	100	100	100	100	100	100
Base: NHS registered males	322	387	313	322	308	239	92	1986
Females								
Not at all	14	16	26	27	28	27	26	23
Once only	15	18	15	15	17	18	14	16
2-3 times	31	28	25	24	27	18	15	25
4-5 times	17	13	11	14	8	10	11	12
6-10 times	12	12	11	12	10	12	11	12
More than 10 times	10	13	9	9	10	14	22	12
Total	100	100	100	100	100	100	100	100
Base: NHS registered females	320	396	365	395	353	298	172	2303
Persons								
Not at all	24	24	32	33	30	30	26	28
Once only	20	21	19	17	18	17	15	18
2-3 times	28	26	25	23	24	21	17	24
4-5 times	12	11	10	10	7	10	11	10
6-10 times	9	8	9	9	11	11	11	10
More than 10 times	6	9	6	8	9	12	20	9
Total	100	100	100	100	100	100	100	100
Base: All NHS registered	642	783	678	717	661	537	264	4289

Table 7.2 Number of consultations during previous year with GPs at practice attended, by social class

Table 7.2 Number of consultations during previous year with GPs at practice address, by social class							
Informant consulted GP:	Non-manual		Manual				Total
	I	II	IIIM	IIIM	IV	V	
	%	%	%	%	%	%	%
Not at all	32	31	29	27	26	26	28
Once only	21	20	22	18	17	16	18
2-3 times	24	24	20	26	26	21	24
4-5 times	10	8	10	11	12	9	10
6-10 times	8	9	10	8	8	13	10
More than 10 times	6	7	9	10	10	14	9
Total	100	100	100	100	100	100	100
Base: All NHS registered	255	990	438	1467	706	250	4289

conforms with that of GHS but the relationship here is rather more marked and systematic.

As was to be expected the frequency of consultations varied with the way informants assessed their own general health over the preceding year (Table 7.3), although 5% of those saying their health had been poor said they had not consulted at all.

7.4 Type of practice

There was no evidence that the number of doctors in the practice, or whether or not it was situated in a health centre, influenced the frequency of consultation (Tables 7.4 and 7.5). On the other hand, it appears that large list sizes had a slight deterrent effect (Table 7.6) and that this was most marked in designated areas in which list sizes may be particularly large. For example, amongst the people using GPs in designated areas, 25% of those on lists of 2500 or less had not consulted at all during the preceding year, compared with 36% of those on lists of 3000 or more (Table 7.7).

Features of practices which have no effect on how often people in general see their doctors may nevertheless impinge on particular groups. The elderly are of particular interest here, both because they are likely to have a greater need than others for medical attention and because they may find obstacles to getting it which younger people do not.

Table 7.8 suggests that the number of doctors in the practice made no impact on how often people aged 65 or more saw their doctor. On the other hand those using a health centre were rather less likely than others to have consulted their doctors four or more times during the year—26% of the former had done so compared with 38% of the remainder. In addition, it appears that a large list may have inhibited the elderly in consulting their doctors—not (as was the case for people in general) by deterring them from consulting at all, but by reducing the proportion who consulted four or more times during the year, from about 38% of those on lists of less than 3000, down to 28% of elderly people on larger lists.

Table 7.3 Number of consultations during previous year with GPs at practice attended, by self perceived health status

Informant consulted GP:	Perceived health status				Total
	Very good	Good	Fair	Poor	
	%	%	%	%	%
Not at all	43	26	12	5	28
Once only	24	19	12	5	18
2-3 times	22	28	26	11	24
4-5 times	5	12	14	14	10
6-10 times	4	10	18	21	10
More than 10 times	2	5	18	43	9
Total	100	100	100	100	100
Base: All NHS registered	1741	1440	804	294	4289

Table 7.4 Number of consultations during previous year with GPs at practice attended, by size of practice (number of principals)

Informant consulted GP:	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	
	%	%	%	%	%
Not at all	29	29	27	29	28
Once only	19	18	19	18	18
2-3 times	25	25	23	25	24
4-5 times	10	10	10	7	10
6-10 times	10	10	10	7	10
More than 10 times	7	8	11	10	9
Total	100	100	100	100	100
Base: All NHS registered	724	1853	1230	466	4289

Table 7.5 Number of consultations during previous year with GPs at practice attended, by size of practice (number of principals) and whether in a health centre

Informant consulted GP:	In health centre			Not in health centre			Total	
	1-3 doctors	4-5 doctors	6 or more	1-3 doctors	4-5 doctors	6 or more	In health centre	Not in health centre
	%	%	%	%	%	%	%	%
Not at all	28	28	28	29	27	29	28	28
Once only	21	20	16	18	19	19	20	18
2-3 times	24	23	26	25	23	24	24	25
4-5 times	11	11	16	10	10	10	11	10
6-10 times	9	10	4	10	10	8	9	10
More than 10 times	8	9	10	8	11	10	8	9
Total	100	100	100	100	100	100	100	100
Base: All NHS registered	406	312	84	2154	912	380	802	3454

Table 7.6 Number of consultations during previous year with GPs at practice attended, by average list size of practice

Informant consulted GP:	Up to 1800	1801-2100	2101-2500	2501-3000	3000 or more	Total
	%	%	%	%	%	
	%	%	%	%	%	
Not at all	29	26	27	29	32	28
Once only	16	21	19	18	19	18
2-3 times	26	22	25	24	24	24
4-5 times	10	11	9	11	10	10
6-10 times	9	10	10	11	8	10
More than 10 times	10	9	11	8	7	9
Total	100	100	100	100	100	100
Base: All NHS registered	483	636	1162	1088	723	4289

Table 7.7 Number of consultations during previous year with GPs at practice attended, by average list size and whether in designated area

Informant consulted GP:	Designated area			Non-designated area			Total	
	List: up to 2500	List: 2501-3000	List: 3000 or more	List: up to 2500	List: 2501-3000	List: 3000 or more	Designated	Non-designated
	%	%	%	%	%	%	%	%
Not at all	25	30	36	27	28	30	32	28
Once only	21	14	20	19	19	19	18	19
2-3 times	22	23	22	24	24	25	23	25
4-5 times	10	12	8	10	11	10	10	10
6-10 times	9	13	7	10	10	9	9	10
More than 10 times	12	7	8	10	8	6	8	9
Total	100	100	100	100	100	100	100	100
Base: All NHS registered	130	224	241	2152	864	482	610	3679

Table 7.8 Number of consultations during previous year with GPs at practice attended, by type of practice. Informants aged 65 and over

Informant consulted GP:	Number of principals				Total	
	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Not in health centre	In health centre
	%	%	%	%	%	%
Not at all	27	28	28	30	28	28
1-3 times	37	37	36	30	46	35
4-10 times	22	21	20	22	14	22
More than 10 times	14	13	16	18	12	16
Total	100	100	100	100	100	100
Base: NHS registered informants aged 65 or over	149	352	228	70	128	664

Informant consulted GP:	Average list size				Total
	Up to 2100	2101-2500	2501-3000	3000 or more	
	%	%	%	%	%
Not at all	27	26	31	27	28
1-3 times	34	36	33	44	36
4-10 times	23	17	24	18	21
More than 10 times	15	21	13	10	15
Total	100	100	100	100	100
Base: NHS registered informants aged 65 or over	240	205	193	128	801

There was no evidence that people in different social classes were differently affected by the type of practice used.

7.5 The accessibility of the practice

In contrast to the information about the characteristics of the practice, all the evidence about accessibility was obtained from informants, but some of it, such as the ease of reaching the surgery, was necessarily more subjective than, for example, the distance to the surgery. What stands out in the relationships between aspects of accessibility and frequency of consultation, is that the more objective facts concerning access were the least closely related to the frequency of consultation.

Thus Table 7.9 shows that the proportions of people who had not consulted their doctor at all in the preceding year increased with the distance they had to travel to the surgery, whilst the proportions who had consulted 10 or more times decreased. The difference between those closest to and furthest from the surgery was, however, not very great: 27% of the people living within a mile of the surgery had not consulted their

doctor compared with 34% of those who lived five or more miles away. The trend applies both to those under 65 years and to older people.

On the other hand, the variation in the number of consultations with informants' assessment of how easy they found the journey was more considerable (Table 7.10). The direction of the relationship, however, was not what might at first be expected, for it was those who reported the journey as easy who were least likely to have consulted at all, and conversely those who said it was difficult who were most likely to have consulted 10 or more times. The most obvious explanation is that it is people who suffer from ill health who both consult most frequently and who are liable to find the journey to the surgery difficult.

The elderly are the most likely to suffer from chronic ill health, but the trend applied equally to them and to younger people. This does not dispose of the possibility that it is being unwell that contributes to the difficulty of the journey, since frequent consulters amongst younger people are presumably also prone to ill health.

Table 7.9 Number of consultations during previous year with GPs at practice attended, by distance from surgery

Informant consulted GP:	Less than 1 mile	1-2 miles	2-5 miles	5 miles or more	Total
	%	%	%	%	%
Not at all	27	26	32	34	28
Once only	18	21	18	20	18
2-3 times	25	24	24	21	24
4-5 times	11	9	11	8	10
6-10 times	9	11	8	10	10
More than 10 times	10	10	7	6	9
Total	100	100	100	100	100
Base: All NHS registered	2102	1124	842	202	4289

Table 7.10 Number of consultations during previous year with GPs at practice attended, by ease of journey to doctors

Informant consulted GP:	Ease of journey				Total
	Very easy	Fairly easy	Fairly difficult	Very difficult	
	%	%	%	%	%
Not at all	25	24	15	10	24
Once only	20	20	16	25	20
2-3 times	27	24	22	14	26
4-5 times	10	11	12	25	11
6-10 times	10	10	17	9	10
More than 10 times	8	11	17	18	9
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	2390	1289	160	44	3920

As will be shown later (Chapter 9) it was elderly people who were most likely to find it easy to get their doctors to visit them at home. This no doubt explains why they were able to consult as frequently as they did despite the fact that they were liable to find the journey to the surgery difficult (see Chapter 4).

The extent of surgery hours, like the distance to the surgery, is an objective fact about accessibility, but it was shown earlier that nearly a quarter of informants did not know exactly what the hours were. It is also possible that some who gave opening and closing times were mistaken. However this may be, it is curious that the people reporting the earliest opening and latest closing times (starting before 9 am and ending 6.30 pm or later) were amongst the least likely to have consulted at all in the previous year or to have consulted 10 or more times (Table 7.11).

It did appear, however, that on the whole the earliest opening time (before 9 am) was associated with the highest frequency of consultation whereas, very oddly, the latest closing time (6.30 pm or after) was associated with the lowest frequency. In general these associations held for those under 65 and for older people, and for the employed and unemployed. There is no obvious explanation for these relationships: do early opening times really increase accessibility and therefore consultations? Or is it that people who consult frequently go early in

the day and therefore know, as others may not, that the surgery is open before 9 am? In any case it is not apparent why people who believe the surgery to be open late should tend to consult less often than others. The true effect, if any, of surgery hours on consultation rates would be easier to assess if information about the former had been collected from practices rather than patients.

There was rather little relationship between the reported convenience of surgery hours and the frequency of consultations, although it was in the expected direction; thus, for example, 33% of the people who said the hours were very convenient had consulted four or more times in the past year, compared with 21% of the small number who said they were very inconvenient (Table 7.12).

Whether there was an appointment system, or receptionist evidently made no difference to how often people said they had consulted (Tables 7.13 and 7.14).

People's view of their doctor's approachability was related to how often they had sought his advice in that those with the most favourable view were the most likely to have consulted him 10 or more times (Table 7.15). This was true both of the elderly and of those under 65. Thus it was not due to the greater propensity of the elderly (the most frequent consulters) to hold a

Table 7.11 Number of consultations during previous year with GPs at practice attended, by reported surgery hours

Informant consulted GP:	Begins before 9.0			Begins 9.0-9.30			Begins 9.30 or later			Total
	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	Ends before 6.0	Ends 6.0-6.30	Ends 6.30 or later	
	%	%	%	%	%	%	%	%	%	%
Not at all	10	18	24	20	19	24	18	18	25	24
Once only	28	18	16	16	18	20	21	20	20	20
2-3 times	18	24	28	30	28	27	27	26	28	26
4-5 times	20	11	12	12	14	10	17	11	7	11
6-10 times	7	14	11	11	11	10	13	15	13	10
More than 10 times	18	14	10	12	11	9	4	10	8	9
Total	100	100	100	100	100	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	81	196	222	261	722	900	60	140	266	3920

§This total includes those informants who reported only 1 surgery per day, or who did not know surgery times.

Table 7.12 Number of consultations during previous year with GPs at practice attended, by convenience of surgery hours

Informant consulted GP:	Surgery hours considered to be:				Total
	Very convenient	Fairly convenient	Fairly inconvenient	Very inconvenient	
	%	%	%	%	
Not at all	22	25	22	31	24
Once only	19	20	23	19	20
2-3 times	25	28	27	29	26
4-5 times	12	10	11	6	11
6-10 times	11	10	8	9	10
More than 10 times	10	8	8	6	9
Total	100	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	2008	1586	180	67	3920

Table 7.13 Number of consultations during previous year with GPs at practice attended, by use of appointment system

Informant consulted GP:	Informant attends practice with:			Total
	Appt. system at all surgeries	Appt. system at some surgeries	No appt. system	
	%	%	%	
Not at all	24	22	24	24
Once only	20	22	20	20
2-3 times	26	24	26	26
4-5 times	11	11	10	11
6-10 times	10	14	11	10
More than 10 times	9	7	10	9
Total	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	2520	310	1028	3920

Table 7.14 Number of consultations during previous year with GPs at practice attended, by presence of receptionist

Informant consulted GP:	Informant attends practice:		Total
	With receptionist	Without receptionist	
	%	%	
Not at all	24	24	24
Once only	20	21	20
2-3 times	26	25	26
4-5 times	11	7	11
6-10 times	10	13	10
More than 10 times	9	10	9
Total	100	100	100
Base: Informants who had been to surgery in previous 5 years	3678	234	3932

favourable view of their doctor in this respect. The meaning of the relationship however is unclear: were those whose doctors were friendly, forthcoming and so on encouraged to consult; or did frequent consultations generate appreciation of the doctor's manner?

The same difficulty of interpretation applies to the similar relationship between frequency of consultation and people's view of the surgery as 'welcoming' or not (Table 7.16).

Perhaps people who became familiar with the surgery surroundings and staff through frequent visits come to regard the place as welcoming; or perhaps people who

Table 7.15 Number of consultations during previous year with GPs at practice attended, by approachability of doctor

Informant consulted GP:	Informant's view of doctor's approachability:					Total
	Very favourable	Favourable	Mixed	Unfavourable	Very unfavourable	
	%	%	%	%	%	
Not at all	23	30	35	42	25	28
Once only	18	19	18	19	24	19
2-3 times	24	27	24	20	29	24
4-5 times	11	9	9	7	7	10
6-10 times	11	9	7	7	8	10
More than 10 times	12	6	7	5	6	9
Total	100	100	100	100	100	100
Base: NHS registered informants who had ever had contact with a doctor at the practice they attend	2378	842	352	536	124	4234

were made to feel at ease visited the surgery when others who were not but felt equally unwell decided against a visit.

Even if unapproachable doctors and unwelcoming surgeries do deter people from consulting when they should, it is not immediately obvious how either could be methodically changed. On the other hand, aspects of

the surgery which are susceptible to improvement through administrative action and guidance—efficiency, tidiness, and modernity—did not appear to be related to the frequency of consultation in any systematic way (Tables 7.17, 7.18, 7.19).

The true effects of distance and practice characteristics on people's consultation behaviour might be concealed

Table 7.16 Number of consultations during previous year with GPs at practice attended, by whether surgery thought of as 'welcoming'

Informant consulted GP:	Surgery seen as:					Total
	Very welcoming	Welcoming	Mixed	Unwelcoming	Very unwelcoming	
	%	%	%	%	%	%
Not at all	23	24	22	28	24	24
Once only	18	18	20	21	26	20
2-3 times	22	25	28	27	24	26
4-5 times	11	11	11	9	12	11
6-10 times	12	11	10	9	7	10
More than 10 times	14	10	9	6	7	9
Total	100	100	100	100	100	100
Base: Informants who had been to surgery within previous 5 years	628	935	1370	786	188	3932

Table 7.17 Number of consultations during previous year with GPs at practice attended, by whether surgery thought of as efficient

Informant consulted GP:	Surgery seen as:					Total
	Highly efficient	Efficient	Mixed	Inefficient	Highly inefficient	
	%	%	%	%	%	%
Not at all	23	24	29	18	7	24
Once only	19	19	20	27	25	20
2-3 times	25	28	23	30	30	26
4-5 times	11	11	9	8	10	11
6-10 times	11	9	10	7	18	10
More than 10 times	11	8	8	10	10	9
Total	100	100	100	100	100	100
Base: Informants who had been to surgery within previous 5 years	2000	1245	512	108	42	3932

Table 7.18 Number of consultations during previous year with GPs at practice attended, by whether surgery thought of as tidy and clean

Informant consulted GP:	Surgery seen as:					Total
	Very tidy	Tidy	Mixed	Untidy	Very untidy	
	%	%	%	%	No.	%
Not at all	23	25	28	16	(4)	24
Once only	19	22	21	22	(6)	20
2-3 times	25	27	30	34	(3)	26
4-5 times	12	10	7	5	(2)	11
6-10 times	11	9	8	16	—	10
More than 10 times	10	7	6	6	—	9
Total	100	100	100	100		100
Base: Informants who had been to surgery within previous 5 years	2732	870	251	40	(15)	3932

Table 7.19 Number of consultations during previous year with GPs at practice attended, by whether surgery thought of as modern and spacious

Informant consulted GP:	Surgery seen as:					Total
	Very modern	Modern	Mixed	Old fashioned	Very old fashioned	
	%	%	%	%	%	%
Not at all	22	22	25	25	22	24
Once only	19	22	18	18	21	20
2-3 times	23	26	28	28	27	26
4-5 times	13	12	9	9	11	11
6-10 times	10	9	10	10	11	10
More than 10 times	12	10	9	9	8	9
Total	100	100	100	100	100	100
Base: Informants who had been to surgery within previous 5 years	450	772	1264	910	512	3932

by confounding effects of age, sex and social class. This did not, however, seem to be the case: a detailed examination of the relationships when age, sex and social class were controlled revealed no hidden effects of greater intensity than those already shown.

It should, however, be recalled that informants were asked to remember the number of consultations they had made over a rather long period (a year) and also that their answers were grouped so that the calculation of precise rates was not possible.

7.6 Conclusions

In general it appears that the type of practice people use and the way the practices are administered have remarkably little effect on how often people consult their doctors, if their reports of consultations are accurate. Certainly there is no evidence that the more modern forms of practice organisation reduce the

frequency of consultation: people using the larger group practices, those in health centres and ones with receptionists or appointment systems, evidently consulted just as often as others.

On the other hand, being on a large list and living some distance from the surgery did appear to have a slight deterrent effect.

How often people say they consult their doctor, however, depends very much more on their age, sex and social class than on any aspect of the organisation or accessibility of the practices they use.

References

- ¹ *Present state and future needs of general practice* (Third edition). Reports from General Practice No 16. Council of the Royal College of General Practitioners. 1973. p 23.
- ² OPCS. *Morbidity statistics from general practice*. Studies on Medical and Population Subjects No 26. HMSO. 1974.

8 Changing doctors

8.1 Introduction

The preceding chapters have shown which organisational and administrative features of practices reduce or increase the ease with which people can get to and use their doctor's services, according to their own views of the matter and judged by the effect of practice characteristics on how often they visited their doctor's surgeries. Another way of finding out which features are important to people is to consider the reasons they give for changing or contemplating changing doctors and how they set about choosing a new doctor. This is the main subject of the present chapter, but since the ease of registering with another doctor is itself an aspect of accessibility, we shall also consider the extent to which people who had changed doctors had experienced difficulties in re-registering.

As in earlier chapters this will be concerned only with the people who were registered with general practitioners as NHS patients, who formed 99% of the sample. Over half the 54 people who were not registered were either serving with the armed forces and used service doctors (16 people) or used private services (15 people).

The remaining 23 people were not registered for a variety of reasons; some had until recently been living overseas, others had not been to a doctor for many years and had not registered in their present area. A few were unregistered either because their former doctor had given up his practice or because they had disagreed with their doctor and had been removed from his list but had not re-registered. The last two groups, who may have real problems of access, formed less than 0.3% of the total sample.

8.2 How often do people change their doctor?

The question cannot be answered directly from the present enquiry, since people were asked only for how long they had been registered with the practice they currently used. This means we do not know how often people had changed doctors before their most recent registration. The evidence about the duration of registration is nevertheless of a kind which provides a good indication of the degree of stability in people's attachments to practices.

Informants were treated as having been registered with their present practice for the period during which they said they had been on his list, even if the doctor had changed or the practice had moved or been reorganised.

In general, the findings suggest considerable stability: about 60% of informants had been registered with their present practice for at least 10 years, and only 4% had registered within the year preceding the survey.

As Table 8.1 shows, even amongst the youngest (16-24 year olds) about 60% had been registered with their present practice for at least 10 years, and the only group to differ markedly from the general picture was that of 25-34 year olds of whom only about a third had been registered for as long as 10 years. Their deviance is no doubt due to the high proportion of the group who must have married and set up home at a new address during the preceding decade. In fact 90% of the group had moved to their present address during the past 10 years compared with only just over half the sample as a whole and as Table 8.2 shows, there was a relationship between duration of registration and residence at current address.

The relationship is in fact less close than might be expected. Except for the people who had lived for 20 years or more at their present address, round about half of each 'duration of residence' group had been registered with their present practice for longer than they had been living at their present address. The more enduring attachment to practices than to addresses was evidently not due to faulty memories, for about half the 310 people who had moved in the preceding year said that they intended to remain with the practice they used before the move.

Undoubtedly the high proportion of movers staying with their former doctor's practice reflects the fact that most moves are made over short distances*. Nevertheless, moves, even within their doctor's practice area, provide people with an opportunity to change practices if they wish to do so, but clearly many did not change.

It is worth mentioning in passing that there was greater stability of attachment in the manual than non-manual group, so that about half of the people in Social Class I, for example, had changed practices in the preceding 10 years but less than a third of those in Classes IV or V. This too seemed to be related to the relative propensity to move home: over two-thirds of Class I had moved within the previous 10 years, but only 50% of Classes IV and V.

* About 60% of moving households move less than five miles from their previous address. *General Household Survey, 1976*, HMSO, Table 5.50, p 159.

Table 8.1 Length of registration at present practice, by age

Length of registration	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Less than 1 year	7	9	4	2	3	2	3	4
1 year up to 2 years	8	11	4	4	4	2	2	6
2 years up to 5 years	12	22	11	9	7	8	8	12
5 years up to 10 years	12	22	22	14	14	13	9	16
10 years up to 20 years	20	11	32	24	16	12	19	19
20 years or more/since birth	40	24	25	47	53	61	59	42
Not known	1	..	1	1	2	2	1	1
Total	100	100	100	100	100	100	100	100
Base: All NHS registered	642	783	678	717	661	537	264	4289

Table 8.2 Length of registration at present practice, by length of time living at present address

Length of registration	Time at present address						Total
	Less than 1 year	1-2 years	2-5 years	5-10 years	10-20 years	20 years or more	
	%	%	%	%	%	%	%
Less than 1 year	38	6	2	2	1	1	4
1 year up to 2 years	8	43	4	2	1	1	4
2 years up to 5 years	11	11	44	4	2	4	12
5 years up to 10 years	9	10	12	48	5	4	16
10 years up to 20 years	11	10	12	14	47	5	19
20 years or more/since birth	22	20	24	29	43	83	42
Not known	..	1	1	1	1	2	1
Total	100	100	100	100	100	100	100
Base: All NHS registered	321	338	742	940	1042	906	4289

8.3 Reasons for changing practices

The people who had changed practices within the previous 10 years were asked why they had done so on the last occasion. It has just been shown that duration of registration is related to time at present address and that many who move do not change practices. Table 8.3 reveals that amongst those who had changed practices, the great majority had done so because they had moved, and that half the remainder had changed because their former doctor had died or retired. In all, 90% of the people who had changed practices had done so because they had little or no option. Only about 5% had changed because they were dissatisfied with the personal or professional behaviour of their previous doctor, and a negligible proportion (included in 'other reasons') mentioned dissatisfaction with organisational or administrative features of the practice.

8.4 Reasons for contemplating change

It is clear that very few people change doctors except when they are obliged by circumstances to do so. But it is possible that more people consider changing doctors because they are dissatisfied than actually do so. This appears to be true in that only 2% of the total sample (and 5% of those who had changed doctors) had changed to their present doctor in the preceding 10 years because they were dissatisfied with their former GP, but 9% had actually considered doing so, including 2% who were concerned not about the doctor but about the inaccessibility of the surgery (Table 8.4). Of the 9% who had ever thought of changing, however, only about half were still considering doing so.

It can be seen from Table 8.4 that, although the trend was slight, older people were the least likely to say they had thought of changing doctors.

Table 8.3 Reasons for changing practice, by age

Registered with new practice in previous 10 years, on last occasion because:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Changed address/previous practice too far away	83	87	79	77	68	73	68	80
Previous doctor retired or died	8	3	7	11	22	19	24	10
Dissatisfied with treatment/attitude of previous doctor	3	5	5	8	8	2	6	5
Other reasons	4	4	6	4	2	4	2	4
Not known	2	2	3	1	1	2	—	2
Total	100	100	100	100	100	100	100	100
Base: Informants who registered with present practice in last 10 years	252	505	280	206	190	135	56	1624

Table 8.4 Whether considered changing doctors, by age

Seriously considered changing doctors because:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Present doctor unsympathetic/difficult to talk to	3	4	2	2	2	1	—	2
Dissatisfied with treatment/no confidence in present doctor	2	4	2	3	1	1	—	2
Surgery inaccessible or too far away	3	3	2	2	2	1	2	2
Other reasons eg difficulty of getting to see present doctor, reluctant to make home visits, does not like present doctor	4	4	3	4	3	2	1	3
Not considered changing	89	87	92	92	92	96	98	91
Total§	101	102	101	103	100	101	101	100
Base: Informants registered 6 months or more with present doctor	608	742	645	694	625	524	250	4094

§Some people gave more than one reason for considering changing doctors.

It did appear that the number of doctors in the practice used somewhat affected people's propensity to consider change. Eleven per cent of the people using single-handed practices had thought of changing, but only 6% of those using practices of six or more doctors (Table 8.5). Although the differences are small the trend is clear and may mean that people using the larger practices were rather more likely than the ones using smaller practices to find a doctor to their taste.

There was no evidence that the practice list size influenced people's tendency to consider changing doctors in any systematic way, nor that those using health centres or practices in designated areas were any more or less likely than others to think of changing. The distance of the surgery from people's homes did have some effect however: about 7% of the people living within two miles of the surgery had thought of changing

doctors, compared with 18% of those living five or more miles away.

8.5 How people choose doctors

Although people evidently rarely leave or think of leaving their doctor because of the way the practice is organised or administered, it may be that people who are obliged to change take these things into account when they choose a new doctor.

Informants who had changed practices in the preceding 10 years were therefore asked what had made them decide on the practice they now used. Almost half had chosen the nearest or most convenient practice, and over a third had based their choice on the recommendations of friends, relatives or neighbours, whilst 16% had relied on the recommendations of their former GPs or used their parents' or spouse's GP. Very few indeed (included in 'other reasons') mentioned that administrative or organisational features had influenced their choice (Table 8.6).

Table 8.5 Whether considered changing doctors, by number of doctors in practice

	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Has considered changing doctors	11	9	7	6	9
Has not considered changing doctors	89	91	93	94	91
Total	100	100	100	100	100
Base: Informants registered 6 months or more with present doctor	684	1764	1186	446	4112

Table 8.6 How present practice chosen, by age

Chose practice because:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Nearest/most convenient	40	48	48	52	43	51	43	47
Recommended by friends/neighbours/relatives	31	37	37	40	36	38	49	37
Recommended by previous GP	4	4	5	8	12	8	10	6
Parent's/spouse's GP	21	12	6	4	3	4	2	9
Only one which could accept onto list	2	1	—	—	3	1	2	1
Other reasons	10	9	9	10	13	7	2	9
Not known	6	2	4	1	2	3	2	3
Total§	114	113	109	115	112	112	110	112
Base: Informants who registered with present practice in last 10 years	252	505	280	206	190	135	56	1624

§Some people gave more than one reason why present practice chosen.

There was no consistent relationship between informants' ages and the grounds of choice, although it was of course the younger groups who were most likely to have 'chosen' their parents' or transferred to their spouse's general practitioner.

The manual group were rather more likely than others to have chosen the most convenient practice, and rather less likely to have relied on the advice of friends, neighbours or relatives, a point we shall return to later (Table 8.7).

One reason why people rarely mentioned organisational or administrative features as influencing their choice of doctor may be that they answered the question in terms of how they set about finding a doctor rather than of what kind of doctor's practice they were looking for. Those who consulted friends or neighbours, in particular, may well have asked them for factual information about the doctors and practices in the area. To try to distinguish between the process of finding a new doctor and some of the factors influencing choice, all NHS registered patients were asked firstly how they would set about finding a doctor if they were to move to a new area, and then whether they would prefer a single-handed or group practice and whether they would want

to know anything else about the organisation of the practice before making their decision.

The most frequently mentioned means of finding a new doctor was through personal recommendation—envisaged by 40% of informants. Nearly 20% said they would simply go to the nearest doctor's surgery and 12% that they would ask their present doctor for advice. No other means was mentioned by as much as 10% of informants, but 14% were uncertain what they would do (Table 8.8).

There were marked variations by social class in some of the means proposed—much more so than in the way people who had changed doctors recalled having actually made their choice. Specifically the proportions saying they would ask friends or neighbours declined steeply with social class, from about 60% in Class I to only about 30% in Class V. Conversely the proportions saying they would go to the nearest doctor increased from 12% in Class I to 25% in Class V. The percentages unsure what they would do also rose from Class I to Class V.

These trends were not the result of differential experience of having moved—although as was mentioned

Table 8.7 How present practice chosen, by social class

Chose practice because:	Non-manual			Manual			Total
	I	II	IIINM	IIIM	IV	V	
Nearest/most convenient	%	%	%	%	%	%	%
Recommended by friends/ neighbours/relatives	49	39	52	50	48	51	47
Recommended by previous GP	44	42	37	35	32	29	37
Parent's/spouse's GP	6	6	7	5	9	8	6
Only one which could accept onto list	11	9	7	10	8	8	9
Other reasons	1	1	1	1	1	6	1
Not known	10	12	7	8	8	17	9
	2	4	2	3	2	—	3
Total§	123	113	112	112	108	119	112
Base: Informants who registered with present practice in last 10 years	142	456	162	514	226	67	1624

§Some people gave more than one reason why present practice chosen.

Table 8.8 How would set about finding a new practice, by social class

	Non-manual			Manual			Total
	I	II	IIINM	IIIM	IV	V	
	%	%	%	%	%	%	%
Ask friend or neighbour to recommend one	61	48	42	35	31	29	40
Go to nearest doctor's surgery	12	15	16	21	23	25	19
Ask present GP to recommend one	10	12	11	12	12	15	12
Contact official NHS body (eg health authority/health centre)	9	10	10	10	10	4	9
Contact other official body (eg CAB, police, local authority)	6	8	10	7	6	5	7
Use telephone directory/ yellow pages	8	6	4	5	3	1	4
Don't know/other ways	4	4	4	4	4	3	4
Uncertain what would do	5	9	11	14	17	21	14
Total§	115	112	108	108	105	103	109
Base: All NHS registered	255	990	438	1468	706	250	4289

§Some people gave more than one way of finding a new practice.

earlier, the likelihood of having moved did decline with social class—for even amongst the people who had moved to their present address in the last year or last five years, the same trends were apparent.

The greater tendency of the non-manual compared with the manual group to consult acquaintances, may be seen as a manifestation of their generally greater propensity to try to organise the conditions of their lives*: on the other hand, given that those in the manual group, and particularly people in Classes IV and V, were inclined to find visiting their doctors less easy than others because of their lower level of car ownership, (see Chapter 4) their greater tendency to choose the nearest doctor seems rational.

When asked whether they would prefer a single-handed or group practice when choosing a new doctor, about 60% said they would not mind. Over half the remainder opted for a group practice, but this largely reflects the fact that most people were currently using group practices and that those who expressed a preference were more inclined than not to choose the type of practice they were currently using (Table 8.9). This

pattern was most marked in the case of people who were using single-handed practices.

It is also evident from Table 8.9 that overall the preference for single-handed practices increased with age, whatever the type of practice actually used. But amongst the oldest group the trend was disturbed by an increase in the proportion with no preference. There is therefore no evidence that the elderly were more likely than the middle-aged to prefer single-handed practices.

The main reason for preferring a single-handed practice was that the doctor 'gets to know you/your family',—given by 80% of those having the preference. The main reason for preferring a group practice was that 'there is always a doctor available'—again mentioned by 80%.

The question whether the informants would want to know anything else about the organisation of the practice before deciding whether to register perhaps required more thought, and two-thirds replied that they would not (Table 8.10). Amongst the remaining third, the most commonly required information was whether there was an appointment system and how easy it was to contact the doctor, followed by the times and frequencies of surgeries, and the availability of home visits.

Interestingly enough, it was the people who said they would find a new doctor by asking acquaintances who were the most likely to want to know about organisational features of the practice; the implication is that these people do enquire about the way the practice operates.

* Other examples of this are the greater tendency for:

- Parents in the non-manual than manual group to visit their children's schools: *Children and their primary schools*. A report of the Central Advisory Council for Education, Vol 2. HMSO. 1967. pp 128-129.
- Couples in the manual compared with the non-manual group to have unplanned pregnancies. M Bone, *The family planning services: changes and effects*. HMSO, 1978.
- Women of child-bearing age in the non-manual compared with the manual group to say they plan ahead rather than just 'let things happen': K Dunnell, *Family formation*, 1976. HMSO. 1979.

Table 8.9 Preference for single-handed or group practice, by age and type of practice attended

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
(a) Attends single-handed practice								
Informant would prefer: single-handed practice	20	28	40	36	47	39	38	35
group practice	15	12	9	10	12	6	—	10
No preference	65	60	51	54	41	55	62	55
Total	100	100	100	100	100	100	100	100
Base: NHS registered informants who attend a single-handed practice	112	110	110	122	120	98	51	724
(b) Attends group practice								
Informant would prefer: single-handed practice	9	10	11	16	16	15	16	13
group practice	26	34	32	26	25	23	13	27
No preference	65	56	57	58	58	62	70	60
Total	100	100	100	100	100	100	100	100
Base: NHS registered informants who attend a group practice	526	671	564	594	539	438	212	3550
All informants								
Informant would prefer: single-handed practice	11	13	16	19	22	20	20	17
group practice	24	31	28	23	23	20	11	24
No preference	64	57	56	58	55	60	69	59
Total	100	100	100	100	100	100	100	100
Base: All NHS registered	642	783	678	717	661	537	264	4289

Table 8.10 Organisational features which would be considered when choosing a practice, by age

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Informant would want to know:	%	%	%	%	%	%	%	%
Whether an appt. system or not	12	16	12	11	9	6	2	11
Times and frequencies of surgeries	10	9	7	7	7	4	1	7
The availability of home visits	3	4	4	5	4	4	3	4
The availability/ease of contacting the doctor	8	11	13	12	13	11	7	11
The number of doctors in the practice	2	2	3	4	4	2	..	3
Whether in a health centre or not	1	1	1	1	1	1	1	1
Other features (ante and post natal facilities, condition of the surgery, whether efficiently run)	8	9	8	7	8	6	5	7
Informant would not want to know anything about organisation of practice	70	63	65	65	65	71	81	67
Total	114	115	113	112	111	105	100	111
Base: All NHS registered	642	783	678	717	661	537	264	4289

§ Some people gave more than one answer to this question.

In summary, it seems that most people are not concerned about organisational or administrative features of the practice when choosing a new doctor, and the main considerations are proximity and the recommendations of acquaintances.

8.6 Difficulties in registering with a new doctor

The fact that most people change doctors only when they have to, and that relatively few think of doing so because they are dissatisfied may be explained in a number of ways. Firstly, it may be that most people are satisfied with their current doctor and his practice; and the evidence from the previous chapters is that most are. Secondly, amongst those who are not satisfied, many may believe they are unlikely to find a better doctor, but there is no indication that this was a widespread view, as will be shown later. Lastly, some people may be dissatisfied but believe that changing doctors is difficult.

In fact less than a quarter of the small proportion (5%) of informants who had thought of changing doctors but decided against it, had changed their minds because they thought it would be too difficult to register with another practice. At least some of these people who did expect difficulties knew rather than supposed that they could not get onto the list of a doctor they would have preferred, because they had tried.

In general, however, there was no evidence that registering with a new doctor was difficult. Amongst informants who had changed doctors in the preceding 10 years, only 6% had had to approach more than one doctor before being accepted as a registered patient by their present doctor and this varied little between the countries of the UK, or between the English Regions (Table 8.11). Nor was the difference between people using practices in designated areas and others notable (Table 8.12). In addition, there was no indication that

Table 8.11 Difficulties in registering with new practice, by region and country

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
Approached more than one practice:	%	%	%	%	%	%	%	%	%
Doctor could not accept because:									
list full	3	4	4	3	4	—	4	2	4
other reasons (eg patient lived out of practice area)	1	2	2	2	2	2	..	—	1
Patient decided not to register	1	..	1	1	1	1	2	—	1
Approached one practice only	88	91	90	92	90	90	91	98	90
Not known/ someone else registered	7	3	3	2	4	8	4	—	4
Total	100	100	100	100	100	100	100	100	100
Base: Informants who registered with present practice in last 10 years	353	356	445	246	1400	59	237	46	1624

Table 8.12 Difficulties in registering with new practice in designated and non-designated areas

England and UK

	England		UK		Total
	Designated area	Non-designated area	Designated area	Non-designated area	
Approached more than one practice	%	%	%	%	%
Doctor could not accept:					
list full	6	3	6	3	4
other reasons (eg patient lived out of practice area)	1	2	1	2	1
Patient decided not to register	1	1	1	1	1
Approached one practice only	87	90	87	91	90
Not known/someone else registered	6	4	5	4	4
Total	100	100	100	100	100
Base: Informants who registered with practice in last 10 years	198	1195	206	1418	1624

Table 8.13 Whether informant had to approach more than one doctor, by reasons for wanting to change

Whether approached more than one doctor	Reasons for wanting to change				Total
	Changed address	Previous doctor retired or died	Dissatisfied with previous doctor	Other reasons	
	%	%	%	%	%
Yes	6	5	14	7	6
No	92	92	83	93	92
Don't know	2	3	3	—	2
Total	100	100	100	100	100
Base: Informants who registered with present practice in last 10 years	1294	161	89	64	1624

the ease of registering with a new doctor had changed over the previous 10 years: at whatever point in the decade the most recent registration had occurred, between 6% and 7% of those involved had had to approach more than one doctor.

It should be recalled again, however, that the vast majority of people changed doctors only when circumstances obliged them to change. How easy is it for people to change if they are dissatisfied with their current doctor? The answer seems to be as Table 8.13 shows, that it is easy, but less so than when there is no option. Six per cent of the people who had changed address had had to approach more than one practice before being accepted, compared with 14% of the people who had been dissatisfied with their previous doctor.

It seems clear that the great majority of people have no difficulty in registering with a new doctor, whether they make the change by choice or necessity. Moreover such small proportions of people who are dissatisfied experience or expect difficulty in re-registering that this cannot explain why so few change doctors from choice.

Another explanation suggested above is that some people who are dissatisfied believe they are unlikely to find a better doctor. This view was certainly represented amongst the people who had thought of changing doctors but who had decided against it: several expressed it as 'Better the devil you know . . .'. But it was a rare view held by less than 10% of the small proportion of people who had considered but decided against change.

8.7 Summary

Although not new, the dominant theme of this chapter is the remarkable degree of stability in people's attachments to their doctor's practices. The vast majority change practices only when they move or the practice ceases to operate, and even those who move often remain with their previous doctor if his surgery is not too distant. Attachments are enduring not because people find or expect changing doctors to be difficult, which it rarely is; nor it seems because they believe all doctors to be equally unsatisfactory, but rather because, according to the accumulated evidence of the preceding chapters, they are for the most part satisfied with their doctors and their practices.

9 Home visits and out of hours consultations

9.1 Introduction

The accessibility of the doctor's surgery has been investigated in earlier chapters but it is also possible for a patient to see his GP at home and we now go on to look at people's experiences of asking for and receiving home visits.

Visits made by general practitioners to the homes of their patients can be divided into two categories. First, there are those visits made in the daytime between the morning and evening surgeries which are necessary because the patient is too ill to make the journey to the surgery. Second are the visits which are requested outside of normal surgery hours (in the evening, at night or at weekends) which are sometimes associated with an illness that needs immediate attention. We start by looking at the home visits made by the doctor in the daytime.

9.2 Frequency of requesting daytime home visits

The informants were asked if they had ever requested a daytime home visit from a doctor for themselves or a member of their family and, if they had, how long ago they had last requested such a visit. People who had requested a daytime home visit within the year prior to the survey were asked how many times they had done so

in that year. It is likely the some people's experience of asking for home visits will vary with their personal situation, the type of practice they attend and the area they live in, so we now go on to look at the variation in the frequency of requesting daytime home visits with respect to these three factors.

More than half of all the people who were registered with an NHS doctor had asked their present doctor for a daytime home visit. This proportion was higher among people aged 35 or more of whom about two thirds had asked for a daytime home visit. Similarly, two out of three women said they had requested a daytime home visit compared with only one in two men.

The largest proportions of people who had asked their doctor to make a home visit were found among the women aged 35 to 44 and 75 or more. It is likely that a large number of the requests made by women in the younger of these two age groups were made for their children while among the very elderly the requests were most probably for themselves or their spouses. Among the very elderly women 65% had requested a visit within the last five years, which indicates that their overall experience is mainly recent and not an accumulation from the past.

Table 9.1 Whether informant had requested a daytime home visit by age, sex and length of time since last request

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Males								
Asked for daytime home visit:								
less than 1 yr ago	30	45	58	56	56	63	59	51
1 yr up to 5 yrs ago	11	22	21	19	22	24	35	21
5 yrs ago or more	13	18	26	21	23	22	14	20
Never asked	6	5	11	16	11	17	10	10
	70	55	42	44	44	37	41	49
Total	100	100	100	100	100	100	100	100
<i>Base: NHS registered males</i>	322	387	313	322	308	239	92	1986
Females								
Asked for daytime home visit:								
less than 1 yr ago	40	64	74	71	68	64	74	65
1 yr up to 5 yrs ago	21	35	33	25	23	24	41	28
5 yrs ago or more	15	25	28	30	27	27	24	26
Never asked	4	4	13	16	18	13	9	11
	60	36	26	29	32	36	26	35
Total	100	100	100	100	100	100	100	100
<i>Base: NHS registered females</i>	320	396	365	395	353	298	172	2303
Persons								
Asked for daytime home visit:								
less than 1 yr ago	35	55	67	64	62	64	69	59
1 yr up to 5 yrs ago	16	29	28	22	22	24	39	25
5 yrs ago or more	14	21	27	26	25	25	21	23
Never asked	5	5	12	16	15	15	9	11
	65	45	33	36	38	36	31	41
Total	100	100	100	100	100	100	100	100
<i>Base: All NHS registered</i>	642	783	678	717	661	537	264	4289

Table 9.2 Whether informant had requested a daytime home visit by family composition and length of time since last request

Asked for daytime home visit:	Informant has:				Total
	Children under 5 only	Children under 5 and 5-15	Children 5-15 only	No children under 16	
	%	%	%	%	%
Less than 1 yr ago	38	43	29	21	25
1 yr up to 5 yrs ago	21	26	28	21	23
5 yrs ago or more	1	5	13	11	10
Never asked	40	26	30	47	42
Total	100	100	100	100	100
Base: All NHS registered	296	270	857	2857	4289

Almost a half of the very elderly men had also requested a daytime home visit in the five years previous to the survey, while among the younger adults, women aged 25 to 44 had the most experience of asking for a home visit in the year prior to the survey. We have noted that many of the requests made by women in these age groups are most probably made for their children and so in Table 9.2 we look at the incidence of requesting daytime home visits by family size and household composition.

As expected, the greatest proportion of people requesting daytime home visits is found among people with children and it would appear from the first part of Table 9.2 that the age of children present in the household is an important factor. A greater proportion of people with children aged less than five had requested a home visit in the year prior to the survey than of those living in households without young children. The proportion of people whose most recent request had been five years or more ago was larger among people with children aged five or more than among those with younger children suggesting that the request might have been made when the former group had had young children themselves.

We now go on to look at whether people with restricted mobility were more likely to have experience of asking for a doctor to visit them at home (Table 9.3). Not

Table 9.3 Frequency of requesting daytime home visits by disability and length of time since last request

Asked for daytime home visit:	Restricted mobility	Mobile	Total
	%	%	%
Less than 1 yr ago	52	22	25
1 yr up to 5 yrs	18	24	23
5 yrs or more ago	7	11	10
Never asked for home visit	22	43	42
Total	100	100	100
Base: All NHS registered	269	401	4289

§Total includes 9 people for whom mobility not known.

surprisingly it was found that people who were disabled or had restricted mobility were considerably more likely to have asked their doctor for a daytime home visit at some time than were other people. These figures also explain, to some extent the high proportion of elderly people who have requested a home visit since a large proportion of the group with restricted mobility of some kind are aged 65 or more (see Table 2.4).

When examining the variation in people's experience of requesting daytime home visits in relation to their social class we found that a slightly higher proportion of people in Social Class III manual and non-manual had experience of asking for a daytime home visit than of those in either the higher or the lower classes (61% of both the III manual and III non-manual groups compared with a range of 57% to 54% for people in the other social classes). However the differences were small compared with those which we have seen with respect to other variables.

The preceding tables have shown that the elderly, women aged between 35 and 44, people with children aged less than five and people with restricted mobility were all groups with a large proportion of people who had requested a daytime home visit from a doctor. However, it is not only whether people ever ask for a daytime home visit that is important in terms of the service provided but also how many times they make such requests. Table 9.4 shows for each of the aforementioned groups the number of requests made in the year prior to the survey.

We have seen that 25% of all people had requested a daytime home visit in the year prior to the survey and Table 10.5 shows that 5% of people had, in fact, requested four or more such visits, while 12% had requested only one. The groups of people who were most likely to have requested a home visit (shown in Table 9.4) were also more likely than average to have requested two or more visits. For example, as many as 19% of people with restricted mobility had asked their doctor four or more times to make a home visit in the year prior to the survey.

Another group of variables which could be related to people's experience of home visits is concerned with the type of practice they attend. We investigated the variation in whether or not people have ever requested a daytime home visit with respect to whether the practice was in a health centre or not, whether it was in a designated area or not and the size of the practice list and found there was little or no variation. However the number of doctors working in the practice did seem to have some relationship with the incidence of requesting home visits and these results are presented in Table 9.5.

Table 9.4 Number of requests for home visits made in year prior to the survey by people with a high incidence of requesting visits

No. of requests for home visits in last year	Women aged 35-44	People aged 75 or more	People with children under 5	People with restricted mobility	All informants
	%	%	%	%	%
Never asked for visit	26	31	34	22	41
Not asked in last year	41	30	26	25	34
One visit requested	16	13	16	15	12
2-3 visits requested	11	15	16	18	8
4 or more requested	6	11	8	19	5
Total	100	100	100	100	100
Base: All NHS registered	365	264	566	269	4289

Table 9.5 Incidence of requesting daytime home visits by number of doctors in practice and length of time since last request

Asked for daytime home visit:	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	Total
	%	%	%	%	%
Less than 1 yr ago	20	25	26	25	25
1 yr up to 5 yrs ago	19	23	23	25	23
5 yrs ago or more	11	11	11	11	10
Never asked for home visit	50	41	40	39	42
Total	100	100	100	100	100
Base: All NHS registered	724	1853	1230	466	4289§

§Total includes 16 people for whom practice details not known.

A greater proportion of people who attended single-handed practices than of those attending group practices of some kind said they had never requested a daytime home visit. A smaller proportion of people who attended single-handed practices had asked for a home visit in the year prior to the survey and similarly for both the other time periods mentioned.

Finally in this section we look at whether requests for daytime home visits varied with respect to the type of area the informant lived in (Table 9.6).

Table 9.6 Incidence of requesting daytime home visits by type of area in which informant lives

Asked for daytime home visit:	Rural	Non-rural	Total
	%	%	%
Less than 1 yr ago	25	24	25
1 yr up to 5 yrs ago	23	23	23
5 yrs ago or more	11	10	10
Never asked	41	43	42
Total	100	100	100
Weighted base: All NHS registered	1008	3281	4289

Table 9.6 shows that there was very little difference between informants living in the two types of area either in whether they had ever requested a daytime home visit or in the length of time since a visit was last requested. One might have expected a higher incidence of requests for home visits in rural areas because of the greater difficulty that the patient has in getting to the doctor's surgery but, perhaps, there is also an appreciation of the difficulties the doctor might have in covering a wide area which leads to the frequency of requests being the same as in non-rural areas.

9.3 Ease of getting daytime home visits

Informants who had requested a daytime home visit in the year prior to the survey were asked whether, on any

of the occasions when they had made a request, the doctor had not come to their home. Only a very small group (less than 10% of those who had requested a visit in the last year) said that there had been any occasion when the doctor had not, in fact, come. Almost a half of this group had been requesting a visit for a child under 16. Where the GP had not made a visit people were asked what had happened instead. Over half said he had made an alternative arrangement such as leaving a prescription at the surgery or specifying a time to attend the surgery guaranteeing that the patient would be seen; 20% said he had given advice over the telephone. Three quarters of those who did not receive a home visit would have preferred it if they had, mainly because they felt the person who needed the doctor had not been well enough to go out or wait in the surgery.

It is possible that people's opinions of how easy it is to get a doctor to make a daytime home visit could influence whether or not they ever request one, while at the same time, it is also likely that people's opinions will have been coloured by their own personal experiences. All the informants were asked how easy they thought it was to get their doctor to make a daytime home visit. Table 9.7 shows how their opinions varied according to the amount of experience they had of requesting daytime home visits.

Most people (82%) thought that it was fairly or very easy to get the doctor to make a daytime home visit. There were 12% who thought it was fairly or very difficult and 6% who said they did not know. The proportion of people who thought it was very easy to get the doctor to make a home visit increased with the number of visits they had requested from about 30% of those who had never requested a visit up to more than twice as many of those who had requested six or more visits.

Table 9.7 How easy informant thinks it is to get doctor to make a daytime home visit by incidence of requesting home visits

How easy informant thinks it is to get daytime home visit	Frequency of requesting daytime home visits					Total
	Never requested visit	Not requested in last year	Number requested in last year			
			1	2-3	4 or more	
	%	%	%	%	%	%
Very easy	29	43	49	50	61	39
Fairly easy	44	44	40	40	34	43
Fairly/very difficult	14	10	10	10	5	12
Don't know	13	3	1	—	—	6
Total	100	100	100	100	100	100
Base: All NHS registered	1781	1446	488	359	204	4289 ^a

^aTotal includes 11 people for whom incidence is not known.

People who said they thought it was fairly or very difficult to get the doctor to make a home visit were asked why they thought this. About a third said it was because the doctor was very busy and they thought he would not have time to visit them. About 30% said the doctor would tell them to come to the surgery if they rang to request a home visit and 15% said that they knew from previous experience that it was difficult. Other reasons given included the distance being too great, or that the doctor would only visit them in an emergency.

We now go on to see how the views about requesting daytime home visits varied with age and sex. Since we have already seen that women and elderly people have more experience of requesting home visits we might expect there to be a variation in their views on how easy it is to get their doctor to come to the house (Table 9.8).

The proportion of people who said they thought it was fairly or very difficult to get the doctor to make a home visit decreased with age from 19% of people aged 16 to 24 to 3% of people aged 75 or more. This variation is to

be expected from previous results given that a smaller proportion of young adults than of older ones had any experience of requesting home visits. However, the variation between the sexes is not as one would expect, for although a greater proportion of women than men had experience of asking for a home visit there is no difference between the proportions of each who thought it would be difficult to get their doctor to make a visit. Although there are slight differences between men and women among the 25 to 44 year olds in the proportions who thought it was easy to get their doctor to make a home visit, these are not as large as might be expected. Bearing this in mind we now go on to see how the informants' views varied in relation to family composition.

We have previously seen (Table 9.2) that a comparatively large proportion of people with children aged less than five had experience of requesting a home visit in the year prior to the survey and yet Table 9.9 shows that nearly a quarter of the people whose children were aged less than five and 18% of those who had older children as well as younger ones thought it was difficult

Table 9.8 How easy informant thinks it is to get doctor to make a daytime home visit, by age and sex

How easy informant thinks it is to get daytime home visit	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Males								
Very easy	20	27	30	39	42	54	57	35
Fairly easy	52	44	52	44	43	37	35	45
Fairly/very difficult	18	20	11	8	8	3	1	12
Don't know	10	9	7	9	7	6	7	8
Total	100	100	100	100	100	100	100	100
Base: All NHS registered males	322	387	313	322	307	239	92	1982
Females								
Very easy	21	34	42	41	50	61	63	43
Fairly easy	50	42	43	45	38	29	27	40
Fairly/very difficult	20	19	11	9	7	5	4	12
Don't know	9	5	4	5	5	5	6	5
Total	100	100	100	100	100	100	100	100
Base: All NHS registered females	320	396	365	395	354	298	172	2300
Persons								
Very easy	20	30	36	40	47	58	61	39
Fairly easy	51	43	48	44	40	33	30	43
Fairly/very difficult	19	20	11	9	7	4	3	11
Don't know	10	7	5	7	6	5	6	7
Total	100	100	100	100	100	100	100	100
Base: All NHS registered persons	642	783	678	717	661	537	264	4289

Table 9.9 How easy informant thinks it is to get doctor to make a daytime home visit by age of children

How easy informant thinks it is to get daytime home visit	Informant has:				Total
	Children under 5 only	Children under 5 and 5-15	Children 5-15 only	No children under 16	
	%	%	%	%	%
Very easy	26	32	40	41	39
Fairly easy	46	44	45	41	43
Fairly/very difficult	23	18	11	10	11
Never asked	5	6	4	8	7
Total	100	100	100	100	100
Base: All NHS registered	296	270	857	2857	4289

to get their doctor to make a daytime home visit. These figures are about twice the proportion expecting difficulty amongst informants with no young children.

We have already noted that of the few cases where the GP did not make a home visit as requested almost a half were for children under 16 and the most common alternative arrangement was to take the child to the surgery. The reasons why people think it is difficult to get the doctor to make a home visit are shown in Table 9.10. These figures give further support to the

Table 9.10 What makes informant think it is difficult to get doctor to make daytime home visit

Informant thinks it difficult because:	People with children aged less than 5	People with no children aged less than 5
Doctor is very busy	34%	32%
Would say come to surgery	38%	28%
Knows from past experience	16%	15%
Have to phone before 10 am	3%	6%
Heard from other people	6%	11%
Other answers	26%	27%

Base: Informants who think it difficult to get doctor to make home visit

116

376

suggestion that GPs are especially liable to tell parents to bring their children to the surgery when asked to visit them at home.

When looking at how people's opinions varied with the characteristics of the practices they attended we found no statistically significant differences between the proportions of people who thought it was fairly or very difficult to get the doctor to make a daytime home visit. Similarly, there was no difference between people who lived in urban or rural areas in how easy they thought it was to get the doctor to make a home visit.

All of the informants who were registered with an NHS doctor were asked if they had ever considered requesting a daytime home visit and then decided not to. Only 4% said they had done this and they gave two main reasons, one being that they decided to wait to see if the complaint got better and the other that they did not think the matter was serious enough to justify requesting a home visit.

9.4 Contacting the doctor outside normal surgery hours

Daytime home visits are part of a general practitioner's daily routine but visits made after surgery hours or on Sundays are considered by some as an additional (but vital) function of the general practitioner. There is a trend, however, for an increasing number of doctors not to be constantly on call but to run rotas with other doctors or to use deputising services¹. This results in calls for the doctor at night or at weekends often being answered by a doctor other than the patient's own GP. In this next section we go on to look at people's experience of contacting the doctor 'out of hours' and what they felt about them.

Two out of five people in the sample had some experience of trying to contact the doctor outside normal surgery hours but only one in five had been directly involved in the process of trying to contact the doctor. In 11% of cases the informant had needed the doctor for himself and someone else had tried to contact the doctor and in 9% of cases informants were relating the experience of other people in their family who were registered with their doctor (Table 9.11). These figures

Table 9.11 Experience of trying to contact doctor outside normal surgery hours

Experience of trying to contact doctor outside surgery hours in last five years	Male	Female	Total
	%	%	%
Informant tried to contact doctor	18	22	20
Informant needed doctor for himself and someone else tried to contact him	11	11	11
Informant not directly involved	10	9	9
Informant has no experience of trying to contact doctor in last five years	61	58	60
Total	100	100	100
Base: All NHS registered	1986	2303	4289

varied slightly for men and women. It is interesting to note that whereas a considerably larger proportion of women than men had asked for a daytime home visit there is only a small difference between the proportions of men and women who had tried to contact the doctor out of hours.

For the rest of this section we shall be investigating the experiences of people who were directly involved in trying to contact the doctor outside normal surgery hours, and Table 9.12 shows how the proportions varied with the age and sex of the informant and who needed the doctor.

Table 9.12 Whether informant had tried to contact doctor in the five years prior to the survey outside of normal surgery hours, by age and sex of informant and who needed the doctor

Informant tried to contact doctor for:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Himself	1	3	2	2	3	1	1	2
Spouse	1	7	8	6	11	13	4	7
Child under 16	1	13	11	4	...	...	...	5
Other relative	6	3	3	4	5	2	...	4
Not tried in last 5 years	90	74	76	84	81	84	95	82
Total	100	100	100	100	100	100	100	100
<i>Base: NHS registered males</i>	322	387	313	322	308	239	92	1986
Females								
Herself	2	5	1	1	2	2	4	2
Spouse	1	3	5	8	9	9	2	6
Child under 16	7	25	17	7	...	...	...	9
Other relative	5	3	6	10	5	2	...	5
Not tried in last 5 years	85	62	71	74	84	87	92	78
Total	100	100	100	100	100	100	100	100
<i>Base: NHS registered females</i>	320	396	365	395	353	298	172	2303
Persons								
Him/herself	2	4	2	1	3	1	3	2
Spouse	1	6	7	7	9	11	2	6
Child under 16	4	19	14	5	...	...	...	8
Other relative	5	4	4	8	5	2	1	4
Not tried in last 5 years	88	68	73	79	82	86	94	80
Total	100	100	100	100	100	100	100	100
<i>Base: All NHS registered</i>	642	783	678	717	661	537	264	4289

As we have already seen in Table 9.11, 20% of the informants had tried to contact the doctor outside normal surgery hours within the five years prior to the survey. This figure varied considerably with age being 12% of the 16 to 24 year olds, 32% of the 25 to 34 year olds and then decreasing with age to 6% of the people aged 75 or more. This overall variation was due to the variation in 'out of hours' calls made for children aged less than 16. Of all people, 8% had tried to contact the doctor 'out of hours' for a child aged less than 16 but, among people aged 25 to 44, 19% had tried to contact the doctor on behalf of a child aged less than 16. The number of people who tried to contact their doctor on behalf of their spouse varied slightly with age being lower at the two ends of the age range shown here which is as one would expect, as there are fewer married people in these two groups than in the other groups. The group called 'other relative' comprises mainly parents and children aged 16 or more.

Looking at the differences between the two sexes we can see that while a greater proportion of younger women than of younger men have tried to contact their doctor outside normal surgery hours there is very little difference among the people aged 55 or more. Once again the overall variation is mostly due to attempts to contact the doctor on behalf of children aged less than 16. For example 25% of women aged 25 to 34 had, in the five years prior to the survey, tried to contact their doctor outside of surgery hours on behalf of a child compared with only 13% of men of the same age.

The proportions of people who had tried to contact the doctor outside surgery hours showed no variation with respect to the different practice characteristics nor did they vary according to whether the informant lived in a rural or non-rural area.

The informants were asked on what day of the week and at what time they had tried to contact the doctor on the most recent occasion. The results are shown in Table 9.13.

Table 9.13 Day of week and time of day informant tried to contact 'out of hours' on last occasion

When tried to contact doctor	%
Weekday 8 am to 8 pm	19
Weekday 8 pm to 8 am	30
Weekend 8 am to 8 pm	33
Weekend 8 pm to 8 am	16
Not known	2
Total	100
<i>Base: Informants who themselves tried to contact doctor out of hours in last 5 years</i>	876

About half the informants were describing incidents that occurred at the weekend while just under a third had made their most recent attempt at contacting the doctor outside normal surgery hours on a weekday evening or night.

Informants who had tried to contact the doctor outside normal surgery hours in the last five years were asked how they went about doing so. About three fifths said the first thing they did was to telephone the surgery, just over a fifth telephoned the doctor at home and a further 12% telephoned an emergency number. Table 9.14 shows to whom the informant spoke according to the method of trying to contact the doctor.

More than half of the people who tried to contact the doctor out of hours actually spoke to a doctor. There were 18% who left a message at the surgery or doctor's home and 16% who left a message at an emergency number or with a mechanical answering device.

Table 9.14 Whom the informant contacted by method of contacting

Whom informant contacted	Method of contacting			Total
	Phoned surgery	Phoned GP's home	Phoned emergency no.	
Spoke to a doctor	% 54	% 70	% 57	% 58
Left message at: surgery/GP's home	19	19	6	18
emergency no./answering device	18	8	31	16
Something else happened	9	3	6	8
Total	100	100	100	100
Base: (see Table 9.13)	542	192	106	876

§Bases do not add to total because of small groups who used different methods of contacting.

Not surprisingly the largest proportion of people who spoke to the doctor was found among the group who phoned the doctor's home. Even among these people, however, 8% had to leave a message with an answering device. There was very little difference in the proportions of people who spoke to a doctor between those who rang the surgery and those who rang an emergency number (54% and 57% respectively).

Table 9.15 Whom informant contacted by whether practice was in a designated area

Whom informant contacted	Designated area		Total
	%	%	%
Spoke to doctor	47	60	58
Left message at: surgery/GP's home	17	18	18
emergency no./answering device	29	15	16
Something else happened	7	7	8
Total	100	100	100
Weighted base: (see Table 9.13)	100	732	876

People registered with doctors in designated areas were less likely to have spoken to a doctor when they tried to contact their GP outside of normal surgery hours than those registered with doctors in other types of area (Table 9.15). They were also more likely to have left a message at an emergency number or on a mechanical answering device. A similar trend was also seen with respect to the number of doctors in the practice and the practice list size (Tables 9.16(a) and (b)). People who attended single-handed practices or practices with a list size of more than 3,000 people were less likely to have managed to speak to the doctor than those attending group practices or practices with a list size of less than 1800 people. In fact, as many as 73% of people who attended practices with the smallest average list size spoke to a doctor when they tried to contact their GP outside normal surgery hours.

Nearly three quarters of the informants living in rural areas who had tried to contact their doctor outside normal surgery hours had spoken to a doctor compared

Table 9.16 (a) Whom informant contacted by number of doctors in practice and average list size

Whom informant contacted:	Number of doctors in practice				Total
	Single doctor	2-3 doctors	4-5 doctors	6 or more doctors	
Spoke to doctor	% 48	% 58	% 61	% 63	% 58
Left message at: surgery/GP's home	20	19	16	18	18
emergency no./answering device	20	17	16	13	16
Something else happened	12	6	7	6	8
Total	100	100	100	100	100
Base: (See Table 9.13)	145	386	252	93	876

Table 9.16 (b) Whom informant contacted by average list size

Whom informant contacted	Average list size of practice					Total
	Up to 1800	1801-2100	2101-2500	2501-3000	3000 or more	
Spoke to doctor	% 73	% 59	% 58	% 60	% 44	% 58
Left message at: surgery/GP's home	13	19	17	19	19	18
emergency no./answering device	7	15	17	15	27	16
Something else happened	7	7	8	6	10	8
Total	100	100	100	100	100	100
Base: (see Table 9.13)	108	126	256	232	140	876

to just over half of those living in non-rural areas. People living in non-rural areas were more likely to have left a message at an emergency number or on an answering device than people who lived elsewhere (Table 9.17).

Table 9.17 Whom informant contacted by type of area in which informant lives

Whom informant contacted	Rural	Non-rural	Total
Spoke to doctor	% 71	% 54	% 58
Left message at: surgery/GP's home	15	19	18
emergency no./ answering device	9	19	16
Something else happened	5	8	8
Total	100	100	100
Base: (see Table 9.13)	208	668	876

Informants who had left a message for the doctor were asked how satisfied they were with having to do so. Just over a fifth said they were dissatisfied and although satisfaction varied with the eventual outcome 15% of those who eventually saw a doctor from their own practice were dissatisfied at having to leave a message (Table 9.18).

Table 9.18 has shown how the informant's satisfaction at leaving a message varied with the eventual outcome

of trying to contact the doctor and we now go on to look at how the outcome itself varied according to the situation the informant was describing and the characteristics of the practice attended by the informant.

Two out of three people who had tried themselves to contact their doctor outside normal surgery hours in the five years prior to the survey succeeded in getting to see a doctor from their own practice (or rather, in getting the doctor to see the person who needed him). There were 19% who saw another doctor while 15% did not get to see a doctor at all (Table 9.19). Whether people managed to see a doctor from their own practice varied with who needed him. In about 70% of cases informants succeeded in getting a doctor from their own practice to see their spouse or other relatives, such as parents, while only 56% of informants who had been trying to contact a doctor on behalf of themselves saw one from their own practice. A comparatively large proportion (24%) of this latter group did not see a doctor at all. However, as the numbers become rather small at this stage it is impossible to investigate why this is so but it seems likely that there were two main reasons. One is that an informant who contacted the doctor for himself was perhaps more likely to be given advice over the phone and the other that, as a group, these people were probably less seriously ill (a patient who was unconscious would not be trying to contact the

Table 9.18 Satisfaction with leaving a message by outcome of attempt to contact doctor

Satisfaction with leaving message	Outcome of attempt to contact doctor			Total
	Saw doctor from own practice	Saw another doctor	Did not see any doctor	
	%	%	No	%
Satisfied with leaving message	85	64	(6)	78
Dissatisfied	15	36	(8)	22
Total	100	100	—	100
Base: Informants who left a message	218	78	(14)	310

Table 9.19 Outcome of attempt to contact the doctor by who needed him

	Who needed the doctor				Total
	Informant	Spouse	Child under 16	Other relative	
	%	%	%	%	%
Patient saw: doctor from own practice	56	71	62	70	66
another doctor	20	18	21	19	19
Did not see doctor	24	11	17	11	15
Total	100	100	100	100	100
Base: (see Table 9.13)	92	276	320	186	876

Table 9.20 Outcome of attempt to contact the doctor by when request was made

	When tried to contact doctor				Total
	Weekday before 8 pm	Weekday after 8 pm	Weekend before 8 pm	Weekend after 8 pm	
	%	%	%	%	%
Patient saw: doctor from own practice	73	68	59	65	66
another doctor	15	16	23	24	19
Did not see doctor	12	16	18	11	15
Total	100	100	100	100	100
Base: (see Table 9.13)	162	256	281	142	876

doctor for himself). Among informants who had tried to contact the doctor on behalf of a child aged less than 16, 17% had not seen a doctor.

Table 9.20 shows that the outcome also varied somewhat with respect to when the informant had tried to contact the doctor. People who had tried to contact the doctor on a weekday before 8 pm were the most likely to see a doctor from their own practice and those who tried at the same time but on a Saturday or Sunday were the least likely to do so. The weekend use by GPs of rota systems and deputising services can be clearly seen in this table.

As was to be expected the informant's success in getting to see a doctor varied according to the process of contacting the doctor. Among informants who had left a message on an answering device or at an emergency number 41% saw a doctor who was not from their own practice compared with 10% of those who left a message at the surgery or doctor's home (Table 9.21). It

Table 9.21 Outcome of attempt to contact the doctor by process of contacting

	Process of contacting		
	Spoke to doctor	Left message at surgery/home	Answering device/emergency no.
Patient saw:	%	%	%
doctor from own practice	67	86	55
another doctor	14	10	41
Did not see doctor	19	4	4
Total	100	100	100
Base: (see Table 9.13)	504	158	144

is interesting to note, however, that among people who had actually spoken to the doctor 19% did not finally see him as compared with only 4% of those who had not spoken to the doctor. This could indicate that some of the arrangements made by GPs to save them work, such as answering devices, do not, in fact, help as much as might be expected since talking to the patient or whoever was phoning on their behalf seems to result in fewer visits being needed.

Finally, in looking at how the outcome varied, we turn to the type of practice the informant attended and the area in which he lived (Table 9.22).

Informants who attended practices in designated areas were more likely to have a visit from a doctor who was not from their own practice than informants who attended practices in other areas. This was also true of informants who lived in non-rural areas where 23% saw a doctor from another practice compared with only 7% of informants who lived in rural areas. We also found, as might be expected, that people who attended practices with four or more doctors were slightly more likely to have seen a doctor from their own practice than people who attended single-handed practices or practices with two or three doctors. However, the proportion who did not see any doctor did not vary significantly with respect to the number of doctors in the practice.

Of course, it is not only whether the doctor sees the patient which is of concern to people trying to contact him outside surgery hours but also how long it is before he does so (Tables 9.23(a) and (b)).

Table 9.22 Outcome of attempt to contact doctor by practice area and area in which informant lived

	Practice in:		Informant lived in:	
	Designated area	Non-designated area	Rural area	Non-rural area
Patient saw:	%	%	%	%
doctor from own practice	60	67	77	63
another doctor	27	18	7	23
Did not see doctor	13	15	16	14
Total	100	100	100	100
Weighted base: (see Table 9.13)	98	778	208	668

Table 9.23(a) Time between first attempt to contact doctor and patient being seen according to the process of contacting and the outcome

Time seen after first tried to contact	Process of contacting			Total
	Spoke to doctor	Left message at surgery/home	Answering device/emergency no.	
	%	%	%	%
Less than 2 hours later	87	77	74	81
2 to 5 hours later	9	17	23	14
6 or more hours later	4	5	2	4
Don't know/can't remember	—	1	1	1
Total	100	100	100	100
Base: Informants who saw doctor and had tried to contact him themselves	401	152	138	734§

§Bases do not add to total because of a small group of people who were involved in different processes of contacting the doctor.

Table 9.23(b) Time between first attempt to contact doctor and patient being seen according to outcome

Time seen after first tried to contact	Outcome of attempt to contact doctor		
	Patient saw doctor from another practice	Patient saw doctor	Total
	%	%	%
Less than 2 hours later	83	73	81
2 to 5 hours later	12	23	14
6 or more hours later	5	3	4
Don't know/can't remember	.	1	1
Total	100	100	100
Base: Informants who saw doctor and had tried to contact him themselves	577	169	734

Four out of five people who eventually saw a doctor saw one within two hours of first trying to contact him, but out of the same group there were 4% who did not see a doctor until six or more hours afterwards.

The time between trying to contact the doctor and the patient being seen varied with the process of contacting with more people having to wait a longer time when the message was left at an emergency number or on an answering device. We have already seen that leaving messages in this way was associated with people seeing doctors who were not from their own practice, so it is not surprising that more of the latter group had to wait longer than of the group who saw a doctor from their own practice (Table 9.23).

The informants who eventually saw a doctor were asked how satisfied they were with the length of time they had to wait. The majority (93%) of those who had to wait less than two hours said they were satisfied while, perhaps surprisingly, as many as 55% of those who had to wait for two or more hours were also satisfied.

At the end of this section of questions all informants were asked whether there had been any occasions in the

last five years when they had considered contacting their doctor outside normal hours but had decided not to. The group of people who were most likely to have considered doing so were the group who, in fact, had the most experience of contacting the doctor: people with children. (Table 9.24.)

9.5 Telephone consultations

We have seen in the previous sections that people who asked their doctor to make a daytime home visit or who tried to contact him outside surgery hours were sometimes given advice over the telephone. We now go on to see how common it is in general for people to be given advice or to consult their doctor in this way.

A tenth of the sample said that on at least one occasion in the last year, they had been given advice by their doctor over the phone instead of seeing him in person. Once again, this was more often the case in households where there were children, particularly children aged less than five (Table 9.25).

We also found that informants in the higher social class groups were more likely to have been given advice over the telephone (18% of Social Class I compared with 4% of Social Class V). As there is some variation in the availability of a telephone with respect to both social class and age this may account for some of the differences we have found here.

Four out of five people were satisfied with being given advice over the telephone mainly because this was what they were expecting. About 50% of people had only phoned the doctor for advice or reassurance and a further 10% had phoned for a repeat prescription.

9.6 Summary

Daytime home visits

More than half of all informants who were registered with an NHS doctor had, at one time or another,

Table 9.24 Whether informants had considered contacting the doctor out of hours but had not done so, by family composition

Whether considered contacting doctor outside surgery hours	Informant has:				Total
	Children under 5 only	Children under 5 and 5-15	Children 5-15 only	No children under 16	
	%	%	%	%	%
Considered and not done so	22	22	15	8	11
Not considered it	78	78	84	92	89
Total	100	100	100	100	100
Base: All NHS registered	296	270	856	2857	4289

Table 9.25 Whether or not informant has been given advice over the telephone for different family compositions

	Informant has:				Total
	Children under 5 only	Children under 5 and 5-15	Children 5-15 only	No children under 16	
	%	%	%	%	%
Been given advice over phone	29	29	14	5	10
Has not	71	71	86	95	90
Total	100	100	100	100	100
Base: All NHS registered	296	270	856	2857	4289

requested a daytime home visit. People with children aged less than five, women aged 35 to 44, the very elderly and people with restricted mobility were all groups with a high frequency of requesting home visits.

Most people thought it was easy to get their doctor to make a home visit although a comparatively high proportion of people with children aged less than five thought it was difficult.

Out of hours contact

Twenty per cent of the informants had themselves tried to contact their doctor outside normal surgery hours. The overall variation in this proportion with age and sex was due mainly to the variation in the number of calls made for children under 16 for whom 40% of out of hours calls were made.

People who phoned the doctor's home were the most likely to speak to the doctor rather than have to leave a message as were people who attended large group

practices or practices in non-designated areas. Of those people who had to leave a message rather than speak to their doctor 22% were dissatisfied with this.

Informants who had tried to contact their doctor out of hours were more likely to see their own doctor rather than another doctor if the call was made on a weekday before 8 pm rather than at other times.

Four fifths of people waited two hours or less before they saw a doctor. A greater proportion of people who saw a doctor other than their own had to wait for two hours or more than of those who eventually saw their own doctor. Even so 55% of those who had to wait for two or more hours were satisfied with the length of time they waited.

Reference

¹Ann Cartwright and Robert Anderson. *General Practice revisited*. Tavistock Publications. 1981.

10 Alternatives to consulting the doctor

10.1 Introduction

Although it seems that only a small minority have difficulty in trying to see a doctor, it is possible that, on some occasions, people may decide to seek other sources of advice or treatment. In this chapter we have examined the extent to which informants had sought medical advice or treatment from pharmacists and hospital casualty departments instead of seeing their GP, the circumstances in which they took this action and the reasons why they decided against consulting their doctor. These, of course, are not the only alternatives to consulting general practitioners and we exclude from consideration advice and treatment obtained from osteopaths, acupuncturists and other practitioners of non-conventional medicine as well as self-medication. It is worth mentioning in connection with pharmacists that self-medication, in terms of the number of items consumed (although not in money terms) is probably twice as great as prescribed-medication¹. It is also probably much more extensive than is suggested by the proportion of people who have sought the advice of a pharmacist, (which is given in the next section), for another enquiry indicates that only about a third of pharmacy sales of non-prescribed medicine is accompanied by requests for advice².

10.2 Advice from the pharmacist

Pharmacists are probably the most readily accessible source of advice about ailments available to the general public and, while it is not their formal function to act in

a consultative capacity, people do sometimes seek their advice. To find out the extent to which people approach pharmacists as an alternative to consulting their GP, informants were asked whether there had been any occasions in the previous year when they had asked for advice in a chemist's shop instead of going to their doctor. Approximately one seventh (15%) said that they had although, as far as can be judged, the complaints they were suffering from appear to have been, on the whole, of a fairly minor nature. For example, over two-fifths mentioned various sorts of respiratory conditions, such as colds and influenza and a further quarter had had stomach or skin complaints.

Table 10.1 shows the proportions who had consulted the pharmacist instead of their doctor according to age and sex. It is of interest that the differences between men and women follow the same pattern as the variation in GP consultation rates, with proportionately almost twice as many women as men having used the chemist as an alternative source of advice (19% and 11% respectively). In contrast, the age variation shows the opposite trend. Only 5% of informants aged 75 years and over had approached the pharmacist instead of seeing their doctor, as compared with 25% of those aged 25 to 34 years. Although it may be that, when there is a choice, the elderly prefer to consult their GP rather than the pharmacist, it is probable that they are the people most likely to have health problems which are generally accepted as requiring medical attention. Thus,

Table 10.1 Use of the pharmacist as an alternative to the doctor by age and sex

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Had asked advice from the pharmacist	11	16	14	9	8	7	4	11
Had not asked advice from the pharmacist	89	84	86	91	92	93	96	89
Total	100	100	100	100	100	100	100	100
<i>Base: All NHS registered males</i>	322	387	313	322	308	239	92	1986
Females								
Had asked advice from the pharmacist	21	24	23	20	13	7	5	19
Had not asked advice from the pharmacist	79	76	77	80	87	93	95	81
Total	100	100	100	100	100	100	100	100
<i>Base: All NHS registered females</i>	320	396	365	395	353	298	172	2303
Persons								
Had asked advice from the pharmacist	16	25	19	15	10	7	5	15
Had not asked advice from the pharmacist	84	75	81	85	90	93	95	85
Total	100	100	100	100	100	100	100	100
<i>Base: All NHS registered persons</i>	642	783	678	717	661	537	264	4289

the pharmacist may rarely be a feasible alternative for them.

As Table 10.2 shows, there was no consistent variation according to social class in the extent to which people had consulted the pharmacist rather than their doctor and the only significant difference in relation to geographical location was between Wales and Northern Ireland, where 13% and 21% respectively had taken this

course (see Table 10.3). Similarly, neither the characteristics of the practice at which the informant was registered nor even such considerations as the ease of travelling to the surgery or the convenience of the surgery hours seem to have very much bearing on people's inclination to seek alternative treatment (see Tables 10.4, 10.5 and 10.6). The one practical consideration which does appear to have some relevance is the ease with which people can arrange an appointment.

Table 10.2 Use of the pharmacist as an alternative to the doctor by social class

	Non-manual		Manual		Total
	I, II	IIINM	IIIM	IV, V	
Had asked advice from the pharmacist	17	13	16	13	15
Had not asked advice from the pharmacist	83	87	84	87	85
Total	100	100	100	100	100
Base: All NHS registered	1244	438	1468	956	4289

Table 10.3 Use of the pharmacist as an alternative to the doctor by country, region and type of area

									Type of area		Total
	North	Mid-lands	South East	South West	England	Wales	Scotland	Northern Ireland	Rural	Non-rural	
	%	%	%	%	%	%	%	%	%	%	%
Had asked advice from the pharmacist	16	15	14	17	15	18	13	21	14	16	15
Had not asked advice from the pharmacist	84	85	86	83	85	82	87	79	86	84	85
Total	100	100	100	100	100	100	100	100	100	100	100
Base: All NHS registered	1049	927	1049	551	3576	203	391	119	1008	3281	4289

Table 10.4 Use of the pharmacist as an alternative to the doctor by characteristics of practice (number of doctors; average list size; whether in a Health Centre)

	Number of doctors				Total
	1	2-3	4-5	6 or more	
	%	%	%	%	%
Had asked advice from the pharmacist	13	15	16	18	15
Had not asked advice from the pharmacist	87	85	84	82	85
Total	100	100	100	100	100
Base: All NHS registered	724	1853	1230	467	4289

	Average list size					Total
	Under 1800 patients	1801-2100 patients	2101-2500 patients	2501-3000 patients	over 3000 patients	
	%	%	%	%	%	%
Had asked advice from the pharmacist	12	17	15	15	16	15
Had not asked advice from the pharmacist	88	83	85	85	84	85
Total	100	100	100	100	100	100
Base: All NHS registered	483	636	1162	1089	723	4289

	Whether the practice is in a Health Centre		Total
	Health Centre	Not Health Centre	
	%	%	%
Had asked advice from the pharmacist	18	15	15
Had not asked advice from the pharmacist	82	85	85
Total	100	100	100
Base: All NHS registered	802	3454	4289

Table 10.5 Use of the pharmacist as an alternative to the doctor by ease of journey to doctor's surgery by whether or not under 65

	Ease of journey			Total
	Very easy	Fairly easy	Fairly or very difficult	
	%	%	%	%
Age under 65 years				
Had asked advice from the pharmacist	18	19	17	18
Had not asked advice from the pharmacist	82	81	83	82
Total	100	100	100	100
Base: Informants under 65 who had been to surgery in previous 5 years (excluding housebound)	2066	1028	120	3243
Age 65 years and over				
Had asked advice from the pharmacist	6	8	3	8
Had not asked advice from the pharmacist	94	92	97	92
Total	100	100	100	100
Base: Informants over 65 who had been to surgery in previous 5 years (excluding housebound)	319	260	86	670
All ages				
Had asked advice from the pharmacist	16	17	16	16
Had not asked advice from the pharmacist	84	83	84	84
Total	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	2385	1287	205	3920

Table 10.6 Use of the pharmacist as an alternative to the doctor by the convenience of the surgery hours

	Convenience of the surgery hours			Total
	Very convenient	Fairly convenient	Fairly or very inconvenient	
	%	%	%	%
Had asked advice from the pharmacist	15	18	18	16
Had not asked advice from the pharmacist	85	82	82	84
Total	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	2008	1586	246	3920

As Table 10.7 shows, only 15% of informants who found it very easy to make an appointment had approached the pharmacist rather than their GP as compared with nearly a quarter (24%) of those who had some difficulty.

An examination of the more subjective aspects of the doctor's accessibility suggests that the patients' attitudes to both the doctor and the receptionist are likely to have some influence on their choice of medical advice. (See Tables 10.8 and 10.9.) As many as 22% of those who had a fairly critical view of their GP had used the pharmacist as an alternative as compared with only 14% of those who had a favourable impression. The variation according to how the receptionist was perceived showed the same pattern, the differences being even more marked.

Hence, it does seem that people who expect a fairly unsympathetic reception from their doctor are more

likely than others to choose another source of advice about a health problem when this option is open to them. While this is not in itself remarkable, it is of interest that the practical obstacles to seeing the doctor appear to be, on the whole, rather less of a deterrent.

Looking at the reasons why people decided to approach the pharmacist rather than their GP, it is perhaps not surprising to find that nearly a half (47%) felt that their complaint was not serious enough to warrant seeing a doctor. A similar proportion (44%) said that it was quicker or more convenient to ask the pharmacist for advice. Both these reasons suggest that the pharmacist was probably not being used as a real alternative to the doctor by the majority of the people concerned. However, in a small number of cases, informants gave other explanations, sometimes in addition to the two noted above, which imply that a genuine choice was made. The following were each mentioned by around 5% of this group:

Table 10.7 Use of the pharmacist as an alternative to the doctor by the ease of getting an appointment with the doctor

	Ease of getting an appointment			Total
	Very easy	Fairly easy	Fairly or very difficult	
	%	%	%	%
Had asked advice from the pharmacist	15	18	24	17
Had not asked advice from the pharmacist	85	82	76	83
Total	100	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years and whose doctor has an appointment system</i>	950	1156	396	2745

Table 10.8 Use of the pharmacist as an alternative to the doctor by the informant's attitude to the doctor

	Attitude to the doctor			Total
	Favourable	Mixed	Unfavourable	
	%	%	%	%
Had asked advice from the pharmacist	14	17	22	15
Had not asked advice from the pharmacist	86	83	78	85
Total	100	100	100	100
<i>Base: All NHS registered informants who had ever had contact with a doctor at the practice they attend</i>	3220	352	660	4234

Table 10.9 Use of the pharmacist as an alternative to the doctor by the informant's attitude to the receptionist

	Attitude to the receptionist			Total
	Favourable	Mixed	Unfavourable	
	%	%	%	%
Had asked advice from the pharmacist	15	20	27	17
Had not asked advice from the pharmacist	85	80	73	83
Total	100	100	100	100
<i>Base: All NHS registered informants who had had some contact with their doctor's receptionist</i>	2832	278	398	3510

- the pharmacist was very competent/understanding/likely to be more helpful than the doctor;
- the doctor was unsympathetic/would tell them that they were wasting his/her time;
- they were dissatisfied with the treatment or medication prescribed by the doctor.

These explanations do, of course, suggest that the people involved did not have a very favourable impression of either their doctor's manner or of his/her competence. Thus, it is probably not surprising that they were given slightly less frequently by informants registered at practices where there was a choice of doctors than by those at single-handed practices.

We also asked the people who had consulted the pharmacist instead of their doctor about the advice they were given. The majority (87%) were recommended some kind of medication but it is worth noting that nearly a fifth (18%) were advised to see their doctor.

10.3 Treatment at hospital accident and emergency departments

Another source of medical treatment which people may use as an alternative to their GP is a hospital accident and emergency department. Approximately one seventh (15%) of the sample said that they had been (or taken their children) to an accident and emergency department instead of seeing their doctor in the year prior to the survey. However, from their descriptions of the circumstances in which this had happened, it was clear that the majority were referring to situations in which they had needed medical attention urgently, such as after an accident or injury. For example, a half had required treatment for fractures, cuts and bruises. The need for specialised or immediate attention was also suggested by their reasons for choosing the hospital rather than their GP. A half said that the former was better equipped to provide the treatment they needed and a third (35%) had wanted treatment outside surgery hours.

From these findings it does not seem that the public

frequently seek treatment from hospital accident and emergency departments instead of going to see their doctor nor is there any evidence that pharmacists are extensively used as an alternative source of medical advice. In any case, as we have seen, the fairly small proportions who had used these sources rather than their GP had generally wanted either specialised treatment or advice about fairly minor complaints and it was this rather than the difficulty of getting to see the doctor which most often determined their choice. However, these are only two possible courses of action which people may take when they do not wish, or are unable, to consult their doctor. In the next section we have looked in a more general way at the kinds of circumstances in which people may decide against consulting their GP.

10.4 Deciding against consulting the doctor

Around one in eight informants (13%) said that there had been occasions in the previous year when they had seriously considered consulting their doctor and then decided against this. Although this group included some of the informants who had used the pharmacist as an alternative to their GP, the overlap was surprisingly small (less than 4% of the total sample). However, with one exception, the kinds of complaints mentioned by the two groups were very similar with respiratory conditions being again the most frequently mentioned. The exception was in the widely different proportions who had needed treatment or advice about some form of mental illness (for example, nervous stress or depression). Conditions of this kind were mentioned by as many as 10% of the group who had decided against

consulting their doctor but by less than 1% of the people who had sought advice from the pharmacist instead of seeing their GP.

Despite the small overlap, the two groups showed similar patterns of variation according to many of the factors examined. For example, as Table 10.10 shows, the proportions who had decided against seeing their doctor were highest among women and among informants aged under 65 years. Again there was little variation according to social class (see Table 10.11) or to the characteristics of the practice at which the informant was registered (see Table 10.12). However, when aspects relating to the doctor's accessibility are examined, there are some marked differences between the two groups. It will be remembered that it was only the more subjective factors that appeared to have a significant bearing on whether or not people had approached the pharmacist rather than their GP. With respect to deciding against a consultation, however, both the physical and psychological barriers between patient and doctor seem to be important considerations. As Table 10.13 shows, among those who considered the surgery hours inconvenient, 22% had decided against seeing their GP which is double the proportion among those who found the hours very convenient. The differences according to the relative ease of getting an appointment and of travelling to the surgery were of a similar order as was the variation between informants who had a favourable attitude towards their doctor and the group who had a fairly critical view (see Tables 10.13, 10.14, 10.15, 10.16). It is worth noting, however, that even amongst the minorities who were critical of each aspect of

Table 10.10 Deciding against consulting the doctor (in previous year) by age and sex

Whether had decided against a consultation	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Yes	14	15	13	11	10	6	6	12
No	86	85	87	89	89	94	94	88
Total	100	100	100	100	100	100	100	100
Base: NHS registered males	322	387	313	322	308	239	92	1986
Females								
Yes	12	19	20	18	13	10	5	15
No	88	81	80	82	87	90	95	85
Total	100	100	100	100	100	100	100	100
Base: NHS registered females	320	396	365	395	353	298	172	2303
Persons								
Yes	13	17	17	15	12	8	6	13
No	87	83	83	85	88	92	94	87
Total	100	100	100	100	100	100	100	100
Base: All NHS registered	642	783	678	717	661	537	264	4289

Table 10.11 Deciding against consulting the doctor (in previous year) by social class

Whether had decided against a consultation	Non-manual		Manual		Total
	I, II	IIINM	IIIM	IV, V	
Yes	%	%	%	%	%
No	12	13	13	15	13
	88	87	87	85	87
Total	100	100	100	100	100
Base: All NHS registered	1245	438	1467	956	4289

Table 10.12 Deciding against consulting the doctor (in previous year) by type of practice attended

Table 10.12 Deciding against consulting the doctor (in previous year) by type or practice attended						
Whether had decided against a consultation	Number of principals				Total	
	Single doctor	2-3 doctors	4-5 doctors	6 or more		
	%	%	%	%		
Yes	12	13	14	16	13	
No	88	87	86	84	87	
Total	100	100	100	100	100	
Base: All NHS registered	724	1833	1230	467	4289	
	Average list size					Total
	Up to 1800	1801-2100	2101-2500	2501-3000	more than 3000	
	%	%	%	%	%	
Yes	10	13	14	14	13	13
No	88	87	86	86	87	87
Total	100	100	100	100	100	100
Base: All NHS registered	483	636	1162	1089	723	4289
	Whether the practice is in a Health Centre					Total
	In Health Centre		Not in Health Centre			
	%	%	%	%	%	
Yes	15	13	13	13	13	13
No	85	87	87	87	87	87
Total	100	100	100	100	100	100
Base: All NHS registered	802	3454	3454			4289

Table 10.13 Deciding against consulting the doctor (in previous year) by the convenience of the surgery hours

Whether had decided against a consultation	Convenience of the surgery hours			Total
	Very convenient	Fairly convenient	Fairly or very inconvenient	
	%	%	%	
Yes	11	16	22	14
No	89	84	78	86
Total	100	100	100	100
Base: Informants who had been to surgery in previous 5 years (excluding housebound)	2008	1586	246	3920

Table 10.14 Deciding against consulting the doctor (in previous year) by the ease of getting an appointment with the doctor

Whether had decided against a consultation	Ease of getting an appointment			Total
	Very easy	Fairly easy	Fairly or very difficult	
	%	%	%	
Yes	12	13	25	12
No	88	87	75	88
Total	100	100	100	100
Base: Informants who had been to surgery in previous 5 years and whose doctor had an appointment system	950	1156	396	2745

accessibility, no more than a fifth had actually been deterred from consulting.

In view of the relationships shown above, it is very surprising to find that relatively few of the people who had decided against a consultation mentioned problems of accessibility or of the doctor's attitude as the reason for their decision. Less than 10% referred to the physical difficulties involved and under 5% commented adversely about their doctor's manner. In almost all other cases, the explanations people gave suggested that

it was the nature of the complaint which had determined the outcome—either that the ailment was not serious enough to justify seeing the doctor (47%) or that their GP was not, or would not, be able to help (22%).

As might be expected, the second group included a relatively high proportion of people who had continuous or recurrent health problems and, probably not unrelated, of those who had considered seeking advice about some kind of psychiatric condition. The feeling that the doctor was unlikely to be of help could be, of

Table 10.15 Deciding against consulting the doctor (in previous year) by ease of journey to doctor's surgery by whether or not under 65

Whether had decided against a consultation	Ease of journey			Total
	Very easy	Fairly easy	Fairly or very difficult	
Age under 65 years	%	%	%	%
Yes	14	16	22	15
No	86	84	78	85
Total	100	100	100	100
<i>Base: Informants under 65 who had been to surgery in previous 5 years (excluding housebound)</i>	2066	1028	120	3243
Age 65 years and over				
Yes	5	9	12	8
No	94	90	88	92
Total	100	100	100	100
<i>Base: Informants over 65 who had been to surgery in previous 5 years (excluding housebound)</i>	319	260	86	670
All ages				
Yes	13	14	18	14
No	87	86	82	86
Total	100	100	100	100
<i>Base: Informants who had been to surgery in previous 5 years (excluding housebound)</i>	2385	1287	205	3920

Table 10.16 Deciding against consulting the doctor (in previous year) by informant's attitude to the doctor

Whether had decided against a consultation	Attitude to the doctor			Total
	Favourable	Mixed	Unfavourable	
	%	%	%	%
Yes	12	14	20	13
No	88	86	80	87
Total	100	100	100	100
<i>Base: All NHS registered informants who had ever had contact with a doctor at the practice they attend</i>	3220	352	660	4234

course, reflecting an adverse opinion about their own doctor's competence rather than a belief that their condition was not susceptible to treatment from any GP. However, for those who had contemplated treatment for mental illness at least, there is some evidence from the survey to suggest that the latter explanation is most likely to be correct.

All the informants were asked whether or not they would see their doctor if they had felt severely depressed for several weeks. Over a third (37%) said they would not and by far the most frequent reason given was that GPs could not cure this kind of condition. In only 2% of these cases was it the expectation of an unsympathetic reception that was the deciding factor.

10.5 Summary

Not unexpectedly, we find that it is the nature of the person's health problem that is the main reason why

they decide against consulting a doctor. Nevertheless, in each area examined there was some evidence to suggest that when people consider whether or not to see their GP, the mental and physical effort which such action entails are taken into account, even if not consciously acknowledged. Groups who had relatively few problems in this respect were less likely to have contemplated and decided against a consultation or used alternative sources of treatment than those who had some difficulty.

References

- ¹ Karen Dunnell and Ann Cartwright. *Medicine takers, prescribers and hoarders*. Routledge and Kegan Paul, 1972. p 28.
- ² M J Phelan and M H Jepson. The advisory role of the general practice pharmacist. *Pharmaceutical Journal* Vol 224 No 6074. 1980.

11 District nurses and health visitors

11.1 Introduction

In a previous chapter we examined informants' experiences of asking their GP to make a home visit, and we now go on to look at people's views and experiences concerning two other members of the primary health care team who make home visits: the district nurse and the health visitor. In the latter part of this chapter we shall also look briefly at the role played by district nurses and health visitors at the surgery.

Before presenting any survey results it is useful to describe the role of the district nurse and health visitor in the primary health care team. The term 'district nurse' is used in this context to cover all nurses employed by the Health Authority to provide nursing care for people in their own homes. This definition is not an exact one but has been used because it is unlikely that all patients would be able to distinguish between qualified district nurses and other nurses providing services in the community. The arrangement for a district nurse to visit a patient in his/her home can be made by the patient's GP, hospital doctors or nurses, a social worker, a home help, a relative or friend or by the district nurse herself.

Health visitors are also employed by Health Authorities, who have a statutory responsibility to provide a service for mothers and young children. The pattern of service provision is left to the Authorities, but they normally require the health visitor to visit in their homes nursing mothers confined either in hospital or at home, usually when the domiciliary midwife's task is completed. They become aware of the need to visit via the notification of birth sent by the midwife to the local authority. In addition to her scheduled duties the health visitor is also concerned with the health and well being of all children (both before and while they attend school), the elderly and the chronic sick and disabled. Thus the work of the health visitor is mainly concerned with preventive medicine, health education and advice and social welfare. Most home visits by the health visitor are initiated by herself although these can also follow consultations with GPs, hospitals and social workers.

Work is arranged and divided among district nurses and health visitors in two main ways. One is on a geographical basis with the nurse or health visitor being responsible for everyone within a specified area and the other is on an 'attachment to practice' basis where the nurse or health visitor has a formal arrangement to provide services for people on particular GPs' lists. Within either type of arrangement, however, a nurse or health visitor can also work at a surgery, or clinic.

11.2 Home visits from district nurses and health visitors

All informants were asked whether a district nurse or health visitor had visited them at home in the two years prior to the survey. Informants who had been visited were asked who had arranged the visit, what the nurse or health visitor did when she came and whether they would have preferred the doctor to come. People who had not been visited by a district nurse or health visitor in the last two years were asked what they thought district nurses and health visitors did when they visited people at home.

It must be noted that throughout this chapter the distinction between district nurses and health visitors is that made by the informant, although, as we shall see, it seems likely that in a high proportion of cases this distinction was made correctly.

A tenth of the sample said that a district nurse had visited their home in the two years prior to the survey (Table 11.1(a)) but only 3% had, themselves, been the object of the nurse's visit. As might be expected this proportion increased with age from 1% of people aged 16 to 24 to 11% of those aged 75 and over. There was also some difference among people aged 65 or more in the proportions of men and women who had been visited by a district nurse with slightly more women having been visited. Of the people who had been visited by the district nurse themselves, 36% had restricted mobility.

Table 11.1(b) shows the equivalent figures for visits by health visitors although, in this case, the informant's children have been included with the informant because the mother or guardian will also be seen by the health visitor during visits to pre-school children. Overall, 12% of people reported that they had been visited by a health visitor in the two years prior to the survey. This figure rose to 36% of women aged 25 to 34 (the main child bearing age group) presumably because of the duties of the health visitor in relation to young children.

As we asked about the experience of the informants or their children, there is very little difference in the response of the two sexes among the younger adults, although a greater proportion of elderly women than of elderly men had been visited by a health visitor in the two years prior to the survey.

As we described earlier home visits by a district nurse or health visitor can be arranged by a number of different people so informants who had been visited in the two years prior to the survey were asked who they thought had arranged the visit (Table 11.2). Only two age groups are shown because of the small number of people visited by a district nurse.

Table 11.1(a) Whether district nurse had visited home in last two years by age and sex of informant

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
No visits in last 2 years	91	89	92	90	89	88	81	90
Visited member of family	7	10	7	7	8	8	12	8
Visited informant	2	1	1	3	3	4	7	2
Total	100	100	100	100	100	100	100	100
<i>Base: All informants</i>	332	396	318	325	311	242	93	2020
Females								
No visits in last 2 years	93	90	92	91	90	86	80	90
Visited member of family	7	7	5	6	7	6	6	6
Visited informant	..	3	3	3	3	8	14	4
Total	100	100	100	100	100	100	100	100
<i>Base: All informants</i>	326	398	368	397	356	300	175	2323
Persons								
No visits in last 2 years	92	90	92	91	90	87	80	90
Visited member of family	7	8	6	6	7	7	9	7
Visited informant	1	2	2	3	3	6	11	3
Total	100	100	100	100	100	100	100	100
<i>Base: All informants</i>	658	794	686	722	667	542	268	4343

Table 11.1(b) Whether health visitor had visited informant or child at home in last two years by age and sex of informant

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
No visits in last 2 years	92	69	86	97	96	99	96	89
Visited informant or child	8	31	14	3	4	1	4	11
Total	100	100	100	100	100	100	100	100
<i>Base: All informants</i>	332	396	318	325	311	242	93	2020
Females								
No visits in last 2 years	86	64	88	96	98	94	87	87
Visited informant or child	14	36	12	4	2	6	13	13
Total	100	100	100	100	100	100	100	100
<i>Base: All informants</i>	326	398	368	397	356	300	175	2323
Persons								
No visits in last 2 years	89	66	87	96	97	96	90	88
Visited informant or child	11	34	13	4	3	4	10	12
Total	100	100	100	100	100	100	100	100
<i>Base: All informants</i>	658	794	686	722	667	542	268	4343

Table 11.2 Who arranged the home visit for people who had been visited by a district nurse or health visitor in the last two years

Visit* arranged by:	Visited by district nurse			Visited by health visitor		
	16-64	65 and over	All ages	16-64	65 and over	All ages
GP	%	%	%	%	%	%
District nurse	54	71	62	11	24	16
Health visitor	4	12	7			
Hospital	37	10	25	16	11	12
Other	5	7	6	9	14	9
Did not know	—	—	—	30	20	29
				34	31	34
Total	100	100	100	100	100	100
<i>Base: People who had been visited in last 2 years</i>	79	64	143	481	47	528

* Where people had been receiving regular visits these figures refer to the first visit.

It is interesting to note, in comparing the two parts of the table, that people who had been visited by a district nurse were much more likely to believe they knew who had arranged the visit than those who had been visited by a health visitor. It is possible that people are not aware of the health visitor's responsibility of arranging home visits herself. This observation is also supported by the greater diversity of the answers given by the

people who thought they did know (29% had to be grouped into 'other answers' because of their diversity or vagueness). Among people who had been visited by a district nurse a much greater proportion of 16 to 24 year olds than of older people had their visit arranged by a hospital.

Informants were asked what the district nurse or health

visitor did when she visited. This question was included for two reasons: one to check that the informants had correctly distinguished between district nurses and health visitors and the other to relate the informant's preference for the nurse/health visitor or doctor to what the nurse or health visitor had done.

Some visits were made for more than one purpose. Therefore percentages add up to more than 100.

Table 11.3 Reason for home visit of district nurse or health visitor

What sort of things did the district nurse do when she visited you?	%
Gave bath/bod bath	8
Dressed wound/changed dressings	43
Gave injections/inoculations	26
Other medical treatment	7
Non-medical treatment (eg bedpans)	8
Medical checks	10
General advice and welfare	6
Post-natal and checks on children	3
Other	4
<i>Base: Informants who had been visited by district nurse in last 2 years</i>	<i>143</i>
What did health visitor come about?	%
Health and care of babies/children	79
Health problems of adults	11
Living conditions	7
Arranging contact with other social services	8
General advice and welfare	5
Other	7
<i>Base: Informants who had been visited by health visitor in last 2 years</i>	<i>528</i>

One of the main conclusions to be drawn from Table 11.3 is that in general the informants seem to have distinguished between district nurses and health visitors correctly since the descriptions of their visits tie in well with their defined roles. Although people who said the district nurse came to give advice, look after their general welfare or make a post natal visit could well have been talking about a health visitor.

When the informants were asked whether they would prefer to see the district nurse/health visitor or doctor for the kinds of things they had mentioned only 2% of informants who had been visited by a district nurse and 5% of those who had been visited by a health visitor said they would have preferred to see the doctor, the majority of both groups saying they did not mind who they saw.

11.3 Informants' knowledge of role of the district nurse and health visitor

People who had no experience of a district nurse visiting their home in the two years prior to the survey were asked what sorts of things they thought district nurses did while those who had not been visited by a health visitor were asked a similar question relating to health visitors (Tables 11.4(a) and (b)).

One in three people who had not had a home visit from a district nurse said they did not know what a district nurse did compared with almost two out of three people who did not know what a health visitor did. However,

Table 11.4(a) What informants think district nurses do when they make home visits, by age and sex

	Age groups							All ages		Total
	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Male	Female	
	%	%	%	%	%	%	%	%	%	%
Dress wounds etc	23	39	43	46	43	25	17	30	41	36
Give injections	17	24	31	34	27	18	17	18	32	25
Other medical treatment	10	14	12	15	16	11	11	11	14	13
Non-medical treatment*	19	31	38	51	54	44	32	27	49	39
Medical checks	9	12	14	9	8	6	3	8	11	10
Post natal and checks on children	18	24	28	20	10	6	3	16	19	18
Advice and general welfare	23	23	23	19	19	14	14	19	20	20
Other	3	3	4	4	4	4	1	3	3	3
Don't know	49	32	26	22	24	40	51	42	25	33
<i>Base: People who had not seen district nurse in last 2 years</i>	<i>604</i>	<i>711</i>	<i>629</i>	<i>654</i>	<i>597</i>	<i>470</i>	<i>214</i>	<i>1802</i>	<i>2078</i>	<i>3880</i>

*Includes bathing and bed baths.

Table 11.4(b) What informants think health visitors do when they make home visits, by age and sex

	Age groups							All ages		Total
	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Male	Female	
	%	%	%	%	%	%	%	%	%	%
Give advice on:										
Health and care of children	10	28	33	26	13	6	2	12	24	19
Health problems	7	7	8	8	6	5	2	7	6	6
Living conditions	14	13	14	12	9	5	3	12	10	11
Other social services	3	5	8	8	8	6	4	4	8	6
Care of the elderly	4	6	7	9	7	3	2	5	6	5
Pre- and post-natal care	4	8	9	6	4	1	—	3	7	—
Same as district nurse/medical care	1	4	2	2	2	1	4	2	2	2
Other	4	5	6	9	8	7	5	5	8	7
Don't know	70	52	47	52	66	77	83	69	55	62
<i>Base: People who had not been visited by health visitor in last 2 years</i>	<i>584</i>	<i>525</i>	<i>596</i>	<i>696</i>	<i>644</i>	<i>522</i>	<i>240</i>	<i>1787</i>	<i>2022</i>	<i>3816</i>

when looking at the answers given by people who thought they did know, the last two main categories of activities for a district nurse, (post natal/children and general welfare) mentioned by 18% and 20% of people respectively, could very likely refer to the job of a health visitor while less than 9% of the answers given about the job of a health visitor were referring to the work of a district nurse. (Many of the answers in the 'other' category were concerned with giving medical treatment.)

A greater proportion of men than of women said they did not know what either the district nurse or health visitor did. The trends with age in the proportion who said they did not know were also similar for both district nurses and health visitors with a smaller proportion of people in the middle age ranges than of the young adults or the elderly saying they did not know.

People who had not been visited were also asked how they would go about getting a district nurse (or health visitor) to make a home visit if they wanted one. Among people who had not had a district nurse visit their home in the two years prior to the survey 63% said they would ask their doctor, a further 13% said they would contact the surgery and 15% said they had no idea how to go about contacting a district nurse. One half of those people who had not been visited by a health visitor in the two years prior to the survey said they would contact their doctor and 13% said they would contact the surgery if they wanted a health visitor to call. One in five said they did not know how they would set about getting a health visitor to make a home visit.

11.4 District nurses and health visitors at the surgery

In addition to their role in the community many district nurses and health visitors spend some of their working time in attendance at a GP's surgery, in particular those who are 'attached' to individual practices*. (See description at the beginning of this chapter.) We were interested to discover whether people were going to the surgery intending to see the doctor but having instead to see a nurse or health visitor. All informants who had

been to the surgery in the five years prior to the survey were asked if there were any nurses at the surgery who helped with the treatment of patients and, if there were, whether they had ever been seen by a nurse and whether they would have preferred to see the doctor. These informants were then asked similar questions regarding health visitors.

Among people who had been to the surgery in the last five years 42% said there was a nurse working at the surgery and 27% said there was a health visitor attached to their doctor's practice (Table 11.5). It must be remembered, of course, that this information was collected from the informant and as many as 44% of people said they did not know if there was a health visitor attached to the practice.

The proportion of informants who thought there was a district nurse and the proportion who thought there was a health visitor working at the surgery increased with the number of doctors in the practice.

People who attended practices in health centres were also more likely to say there was a nurse or health visitor attached to their practice than those attending other practices (64% compared with 36% for nurses and 49% compared with 21% for health visitors). There was also some variation with the list size of the practice (Table 11.6) with a smaller proportion of informants who attended practices with very small average list sizes than others saying there was a nurse or health visitor attached to the practice.

Of those who said there was a nurse attached to the practice 30% had been seen by her either for themselves or their child while of those who said there was a health visitor only 6% had been seen by her. We now go on, therefore, to look in more detail at what people felt about being seen by the nurse and then briefly at the views of people who had been seen by the health visitor.

Table 11.7 shows that a slightly greater proportion of men than of women had themselves been seen by a nurse at the surgery but, as might be expected, a much larger proportion of women than of men reported that their child had been seen by a nurse so that, overall, women were more likely to have had experience of dealing with

* Some nurses may be employed by the GP(s) as practice nurses. The questionnaire did not differentiate as it was felt that patients might not know whether it was a district or practice nurse.

Table 11.5 Whether informant thinks practice has nurse or health visitor by number of doctors in practice

	Single doctor	2-3 doctors	4-5 doctors	6 or more	Total
	%	%	%	%	%
Yes, there is a nurse	20	36	56	59	42
No nurse	74	52	31	29	47
Don't know	7	12	13	12	11
Total	100	100	100	100	100
Yes, there is a health visitor	14	24	33	36	27
No health visitor	45	32	22	18	30
Don't know	41	44	45	46	44
Total	100	100	100	100	100
Base: Informants who have been to surgery in last 5 years	660	1698	1127	436	3932

Table 11.6 Whether informant thinks practice has nurse or health visitor by list size of practice

	Up to 1800	1801- 2100	2101- 2500	2501- 3000	3000 or more	Total
	%	%	%	%	%	%
Yes, there is a nurse	30	40	45	45	40	42
No nurse	61	51	43	43	48	47
Don't know	10	10	12	12	12	11
Total	100	100	100	100	100	100
Yes, there is a health visitor	21	26	29	29	23	27
No health visitor	37	32	28	27	31	30
Don't know	42	43	43	44	46	44
Total	100	100	100	100	100	100
Base: Informants who have been to surgery in last 5 years	438	580	1074	1002	666	3932

Table 11.7 Whether informant or child has been seen by a nurse at the surgery by age and sex

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	No	%
Males								
Seen by nurse:							(11)	25
for self	29	21	19	31	21	29		
for child	1	4	7	1	—	—		73
Not seen by nurse	70	75	74	68	79	71	(13)	
Total	100	100	100	100	100	100		100
Base: Informants whose GP's practice had a nurse	83	145	110	94	92	86	24	634
Females							%	
Seen by nurse:							24	22
for self	21	18	20	22	23	21	—	10
for child	6	19	20	10	1	—	76	69
Not seen by nurse	73	64	60	69	76	79		
Total	100	100	100	100	100	100	100	100§
Base: Informants whose GP's practice had a nurse	147	201	188	182	124	108	42	992
Persons								
Seen by nurse:							32	23
for self	24	19	20	25	23	25	—	7
for child	4	13	15	7	—	—	68	70
Not seen by nurse	72	68	65	68	77	75		
Total	100	100	100	100	100	100	100	100
Base: Informants whose GP's practice had a nurse	230	346	298	276	216	194	66	1630

§In five cases the nurse had seen both the informant and her child.

a nurse at their GP's surgery. There was some fluctuation with age but no definite trend emerged.

Informants who had seen the nurse at the surgery were asked what she did when they had been seen by her (Table 11.8).

On the whole people seemed to have been seen by the nurse for the types of treatment which a nurse might be expected to carry out at a surgery. Included in the

heterogeneous group of 'other' answers were things such as: assisting the doctor in examinations and minor operations, referring patients to the doctor, taking urine specimens, giving out prescriptions or medicines (sometimes from the doctor but not always) and dealing with minor ailments such as warts, cysts and boils.

One in two people who saw the nurse for themselves or their child also saw the doctor and of the remaining group 82% said they had gone to the surgery intending to see the nurse while only 13% said they had gone to see the doctor (Table 11.9).

A greater proportion of adults aged less than 65 than of those aged 65 or more had gone to the surgery intending to see the doctor but there was very little difference between the proportions of men and women who said this. Since the 'other answers' group comprises mainly people who went to the surgery without the particular intention of seeing either the doctor or the nurse it is perhaps interesting to note that a larger proportion of men than women fell in this group.

Table 11.8 What nurse did when informant or child was seen by her at surgery

	%
Dressed wound/changed dressing	23
Gave injection/inoculation	29
Syringed ears	16
Took blood sample	9
Took blood pressure	5
Other answers	23
Total	105
Base: Informants who had been seen for themselves or child by nurse	483

Table 11.9 Who informant intended to see: people who only saw nurse by age and sex

	16-64	65 or over	Male	Female	Total
	%	%	%	%	%
Intended to see:					
doctor	15	3	11	14	13
nurse	80	90	79	84	82
Other answers	5	7	10	2	5
Total	100	100	100	100	100
Base: Informants who only saw nurse	209	34	89	154	243

Of the very small group of people who had intended to see the doctor but saw the nurse instead almost three quarters said either that they did not mind who they saw or they had preferred seeing the nurse while only nine people said they would have preferred to see the doctor. Overall the majority (70%) of all the people who had been seen by a nurse at the surgery said they did not mind who they saw, while 20% said they preferred to see the nurse. (See Table 11.10.)

As we have already said only 6% of people who thought there was a health visitor attached to their GP's practice had been seen by her. Of these 64 people 95% said they had seen her for one of their children and, not surprisingly, a high proportion of the group (70%) were women aged between 16 and 44. Only two people aged 65 or more had been seen by the health visitor at the surgery. Those who had seen her for their children had mainly been seen for advice on feeding, vaccinations and so on and general checks on progress.

Just over a third of these people saw the doctor as well, a further 60% went intending to see the health visitor while only two people had gone intending to see the doctor but did not see him.

Although the numbers are not large it is interesting to note that a somewhat higher proportion of people who saw the health visitor than of those who saw the nurse said it was her they preferred to see (Table 11.10). It is

Table 11.10 Whether people would have preferred to see doctor when they were seen by nurse or health visitor

Informant would have preferred to see:	People seen by nurse	People seen by health visitor
	%	%
Doctor	9	13
Nurse/health visitor	20	37
Did not mind	71	49
Total	100	100
Base: Informants who had been seen by nurse/health visitor at surgery in last year	483	64

possible that this is due to there being a clearer distinction between the role of the health visitor and the doctor at the surgery than there is between the role of the nurse and the doctor.

From the above findings it seems evident that, in general, people were not being made to see the nurse or the health visitor either at the surgery or at home when they would actually have preferred to see the doctor.

11.5 Summary

One in 10 people reported visits made to their homes by a district nurse in the two years prior to the survey, but only 3% of the sample had been visited for themselves. There were 12% of people who had been visited by a health visitor either for themselves, their children or both. About 60% of people who had been visited by the district nurse said the visit had been arranged by their GP and a further 25% said the hospital had arranged it. However, a third of people who had been visited by a health visitor did not know who arranged the visit and a further 29% gave answers so diverse or vague that they were unclassifiable. It is suggested that people do not realise that the health visitor makes her own arrangements for carrying out her duties in relation to mothers and young children. When asked whether they would have preferred a home visit by the doctor instead of the district nurse or the health visitor the majority of people said they did not mind who came.

One in three people who had not experienced a home visit by the district nurse in the last two years said they did not know what district nurses did. This was true of a far larger proportion (62%) of the equivalent group for health visitors.

When asked whether there was a nurse or health visitor at their doctor's surgery 42% said there was a nurse compared with only 27% who said there was a health visitor. However, the majority of health visitors' contacts are with children, so that patients without young children would be unlikely to see one, 44% of people said they did not know if there was a health visitor. About 30% of people who said there was a nurse at the surgery had been seen by her compared with only 6% of those who said there was a health visitor. A half of the people who saw the nurse were also seen by the doctor and of the other half most had gone to the surgery intending to see the nurse. Once again the majority of people said they did not mind who they saw. We therefore found no evidence to suggest that, except for a tiny minority, people who wished to see a doctor, either at home or at the surgery, were being made to see a nurse instead.

PART III THE OTHER PRIMARY HEALTH CARE SERVICES

12 Use of pharmacies for dispensing services

12.1 Introduction

Pharmacies form an integral part of the facilities available for treatment and health care in the community both by providing access to qualified pharmacists and the opportunity for self medication. Previous evidence in this report has shown the reasons why patients choose to seek advice from pharmacists instead of seeing their doctor, and as noted in Chapter 10, another investigation has shown that self-medication accounts for twice as many items of medicine consumed as prescribed medicine¹. The major function of pharmacies however is to dispense the very large number of prescriptions which are issued by general medical practitioners to the general public. In 1976 over 360 million prescriptions were dispensed* representing an average of more than six prescriptions per person on NHS prescribing lists[§]. Despite this very high demand for dispensing services there has, in recent years, been a substantial decline in the number of pharmacies in operation. In 1976, for example, there were less than 12,000 pharmacies in this country, compared with more than 15,000 in 1955* and this, understandably, has given rise to some concern about the availability of services for dispensing prescriptions.

In view of this situation, the central area of investigation for the present enquiry was the accessibility of pharmacies for dispensing services. In particular, we were concerned to examine how the availability of services varies between rural and non-rural areas and whether there were any groups within the population for whom specific difficulties of access exist. In order to place this in context, however, it is important to know how the need for dispensing services varies amongst the population. We have therefore devoted this chapter to an examination of the extent to which written prescriptions are received and the usual patterns of behaviour when people need a prescription dispensed. The next chapter (Chapter 13) is concerned with location and accessibility of pharmacies for dispensing services.

12.2 Extent of receiving written prescriptions

In order to get some indication of the extent to which people need to get written prescriptions dispensed, we asked respondents to say approximately how many

times in the preceding year they had been given a written prescription for themselves by one of the doctors at their practice. This means that we have some measure of the number of occasions on which patients receive written prescriptions for medication although not the precise number of written prescriptions received (that is, two prescriptions for the same consultation would count as one occasion). Although this measure does not take account of the number of occasions on which respondents had taken prescriptions to be dispensed for other people (eg children or elderly relatives) it does allow us to determine the extent to which patients have occasion to use pharmaceutical services to obtain medication for themselves and, in particular, the identity of the groups which have most need to do so.

Before considering the number of occasions on which written prescriptions were received, we need to say a word about GPs who dispense drugs or medicines. Most patients in the UK obtain their medication by taking a written prescription from their doctor to a pharmacy where the drugs or medicines required are dispensed. However, under specified circumstances*, and most commonly in rural areas, doctors may supply their patients directly with drugs or medicines rather than giving a written prescription. In 1976, there were just under 3000 dispensing doctors in the United Kingdom who dispensed drugs for over 3,000,000 people (representing 5% of the population)[§]. It was obviously important that this group of patients should be identified since their need for dispensing services was likely to be rather different from those on prescribing lists. Although we relied on the people interviewed to provide information about dispensing doctors, 5% said their doctor usually supplied them with medicines or drugs, rather than giving a written prescription, which corresponds with the official statistics shown above.

As would be anticipated only a very small proportion of patients living in non-rural areas said their doctor usually supplied the medication required, and it was found that 86% of those with dispensing doctors lived

* Compiled from published health statistics for England, Wales, Scotland and Northern Ireland (1977).

§ In 1976, there were 55,084,339 patients on NHS prescribing lists (compiled from published statistics for England, Wales, Scotland and Northern Ireland). These figures exclude persons registered with dispensing doctors.

* Patients may ask their doctors to supply drugs or medicines if:

- i) they would have serious difficulty in obtaining them from a chemist, by reason of distance or inadequacy of communication;
- ii) they are resident in an area which is rural in character at a distance of more than one mile in a straight line from the premises of any chemist.

In Scotland the Health Board decides whether or not a doctor should be required to provide drugs or appliances and the grounds for doing so are covered by (i).

Criterion (ii) does not apply.

§ Compiled from published health statistics for England, Wales, Scotland and Northern Ireland (1977).

in rural areas (Table 12.1). There is however some variation between countries in the proportion of patients in rural areas with a dispensing doctor, England showing a significantly higher prevalence than the other countries in all regions other than the North (Table 12.2).

As patients with dispensing doctors may also receive written prescriptions at times, they were included in these sections on the use of pharmacies. However, as the subsequent analysis shows, they have rather less need than patients on prescribing lists to get prescriptions dispensed and this latter group has therefore been separately identified in the evidence which follows.

The number of occasions on which patients had received written prescriptions from their doctors in the year prior to the survey is shown in Table 12.3. It can be seen that under one third of those on prescribing lists had received no written prescriptions at all while over a fifth had been given prescriptions on six or more occasions.

As might be expected, however, relatively few (14%) of patients with dispensing doctors had received any written prescriptions at all.

Of those who had consulted their doctor in the 12 month period concerned, over 90% of those on prescribing lists had received at least one written prescription (Table 12.3). It would be expected however that the number of times prescriptions are received would be closely associated with the extent to which patients consult their doctors, since higher consultation rates suggest both a greater need for, and likelihood of being given some medication. Table 12.4 shows that in the majority of cases the number of occasions on which prescriptions were received was the same as, or greater than, the number of consultations for patients on NHS prescribing lists. The relatively high proportion of cases where the number of occasions prescriptions had been received exceeded the number of consultations is likely to be accounted for by repeat prescriptions, where drugs or medicines previously prescribed are needed con-

Table 12.1 Type of area by whether has dispensing doctor

Informant lives in:	Doctor usually supplies medicines	Doctor usually gives written prescription	Not registered or not known	Total
	%	%	%	%
Rural area	86	19	26	22
Non-rural area	14	81	74	78
Total	100	100	100	100
Base: Weighted for age	109	2009	51	2169*
Unweighted for age				

*Questions about pharmacies were asked only of Sample A—for details see Chapters 1 and 2.

Table 12.2 Informants with dispensing doctors, by region and country in rural and non-rural areas

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Rural areas									
Informant's doctor: usually supplies medicines	9	22	34	23	21	14	7	3	19
usually gives written prescription	88	74	65	72	75	84	93	97	78
Not known/not registered	3	3	2	5	3	2	—	—	3
Total	100	100	100	100	100	100	100	100	100
Base: Informants living in rural areas									
—Weighted for age	104	135	84	76	399	32	54	30	515
—Unweighted for age	125	158	102	89	474	38	68	35	614
Non-rural areas									
Informant's doctor: usually supplies medicines	1	2	1	1	1	—	—	—	1
usually gives written prescription	97	98	96	95	96	99	99	100	97
Not known/not registered	2	1	3	4	2	1	1	—	2
Total	100	100	100	100	100	100	100	100	100
Base: Informants living in non-rural areas									
—Weighted for age	427	332	445	206	1409	74	140	32	1654
—Unweighted for age	510	390	527	247	1674	85	166	35	1860

Table 12.3 Number of occasions on which written prescriptions received, by whether or not has a dispensing doctor

Number of occasions on which written prescriptions received	All informants		Informants who consulted GP in year prior to survey		Total
	Those with dispensing doctor	Those on NHS prescribing lists	Those with dispensing doctor	Those on NHS prescribing lists	
None	86	29	80	7	31
1 only	6	16	8	20	16
2-3	3	21	5	28	20
4-5	2	10	4	13	9
6-10	1	10	2	14	10
More than 10	2	14	2	18	13
Not known/not registered	—	—	—	—	1
Total	100	100	100	100	100
Base: All informants					
—Weighted for age	109	2027			2169
—Unweighted for age	127	2377			2574
Base: Informants who consulted GP in year prior to survey					
—Weighted for age			67	1458	1537
—Unweighted for age			82	1726	1825

Table 12.4 Number of occasions on which written prescriptions received in year prior to survey, by number of consultations

Number of occasions on which written prescriptions received	No consultations	One consultation	2-3 consultations	4-5 consultations	6 or more consultations	Total
	%	%	%	%	%	%
None	86	18	5	1	—	29
1 only	5	54	16	6	2	16
2-3	2	16	54	26	8	21
4-5	2	4	10	41	11	10
6 or more	5	8	15	26	79	24
Total	100	100	100	100	100	100
Base: Informants on NHS prescribing list						
—Weighted for age	568	376	492	204	387	2027
—Unweighted for age	672	435	565	241	484	2400

tinuously or at least for a subsequent period of medication. This might occur in cases where a patient had telephoned their doctor, or a receptionist, to say that their medication was coming to an end. In such circumstances the doctor would certainly have to authorise the repeated medication but may not actually see the patient concerned on that occasion. Indeed a subsidiary question asked during the survey interview ascertained that 39% of the patients had needed to get a repeat prescription during the year prior to the survey and less than half had actually seen the doctor on the last occasion this happened (Table 12.5).

The relationship between the number of consultations and the number of occasions on which prescriptions were received suggests that there is a very high probability of patients being given a prescription whenever they see their doctor. This was confirmed by the evidence that over three quarters of the patients had received a prescription on the last occasion they consulted their doctor although this does vary with their age and sex (Table 12.6). For all age groups under 65 years, a higher proportion of women than of men had received a prescription at their last consultation, although the difference is particularly noticeable amongst those aged 16 to 24 years and those aged 35 to 44 years. Amongst those aged 65 or over, where 82% had received a prescription when they last consulted the doctor, there were no differences at all between men and women.

Table 12.5 Need for repeat prescriptions and use of repeat prescription cards in year prior to survey

Needed repeat prescription in year prior to survey	%
39	
No repeat prescriptions needed	61
Total	100
Base: All NHS registered	
(Sample A)—Weighted for age	2141
—Unweighted for age	2535
On last occasion repeat prescription needed	
Saw doctor in person	45
Did not see doctor but	
—used repeat prescription card§	11
—asked receptionist at surgery	30
—asked friend/relative to collect	7
—wrote to surgery	6
—obtained in other ways	1
Total	100
Base: Informants who needed repeat prescription	
(Sample A)—Weighted for age	832
—Unweighted for age	1060

§ Repeat prescription cards are given to patients who need medication on a continuous basis. The patient obtains a prescription from the doctor's surgery by presenting the repeat prescription card.

There has been much concern over recent years about the very large number of prescriptions which are given annually and the consequent high level of NHS expenditure on drugs, medicines and medical appliances. It has been suggested that while a high proportion of prescriptions will be given because medication is needed to treat the patient's condition, not all are entirely justified from a clinical point of view. It has been

argued on the one hand that this situation has arisen because patients expect to be given a prescription when they see the doctor and feel the consultation has been unsatisfactory unless they have drugs or medicines to 'cure' their complaint. Others have contended that many doctors too readily prescribe medication, often as a substitute for spending longer in consultation with the patient. Whatever the reason it is certainly clear from the survey evidence that a very high proportion of consultations do result in the patient receiving a written prescription and that access to a pharmacy is going to be necessary on most occasions that patients see their doctors.

As we saw earlier, younger women and elderly people of both sexes were more likely than other patients to have received a prescription on their last consultation. As these groups also consult more frequently than others (Chapter 7), it is not surprising to find that quite considerable differences exist between men and women, and between different age groups, in the number of occasions on which prescriptions were received. Table 12.7 shows, for example, that in all age groups, women had received more prescriptions than men. Such differences however are most marked amongst those aged 16 to 34, where just over half of the men had received at least one prescription compared with over 80% of the women. The number of prescriptions received by the elderly is particularly high with almost a third of women and a fifth of men having received 10 or more in the year prior to the survey.

Other variations between groups in the frequency of consultations are paralleled by differences in the number of prescriptions received, as is demonstrated by Table 12.8 which concerns social class. Here we see that people in manual occupations (Groups IIIM, IV and V)

who, as we saw earlier showed higher consultation rates (Chapter 7), had received prescriptions on more occasions than those from non-manual groups. Thus it is the case that, in general, the heaviest users of dispensing services can be identified as the same groups known to have the highest frequency of consultations (Chapter 7).

We noted earlier that just under one third of informants had not been given a written prescription for themselves in the year prior to the survey. It was clear, however, that amongst this group there would be some people who have had prescriptions dispensed for other members of the family such as children or elderly relatives. It was found that a further 6% had in fact been given a prescription to be dispensed for one of their family, leaving approximately one quarter of the sample who had not had to deal with a prescription at all during the period concerned. This latter group, who had had no recent experience of getting prescriptions dispensed, were excluded from much of the questioning about the use of pharmacies.

12.3 Getting prescriptions dispensed

Those who had had at least one prescription to be dispensed in the year prior to the survey were asked if they themselves had taken their last prescription to a chemist's shop or whether someone else had taken it for them. Approximately one fifth of informants said that on that occasion another person had taken it for them although a rather smaller number (11%) said that it was usual for this to happen. Not unexpectedly a high proportion of elderly patients, and particularly those with restricted mobility, fell in this latter group (Table 12.9) because they found it too difficult to get to a chemist's shop themselves. In virtually all cases it was a friend or relative who took their prescriptions for them and it appeared, that in no case, was it difficult for them to find someone to go.

Table 12.6 Whether given written prescription at last consultation, by age and sex

At last consultation:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Received written prescription	62	74	67	71	74	80	85	72
Not given prescription	35	25	32	26	25	18	15	26
Not known	3	2	2	3	1	1	—	2
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	96	124	88	98	111	77	30	624
Unweighted for age	96	124	88	98	111	154	60	731
Females								
Received written prescription	83	76	85	75	82	82	82	81
Not given prescription	16	21	14	20	17	15	16	17
Not known	2	3	1	4	1	2	2	2
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	128	155	134	124	126	102	61	830
Unweighted for age	128	155	134	124	126	203	122	992
Persons								
Received written prescription	74	75	78	73	79	81	83	77
Not given prescription	24	23	21	23	21	16	16	21
Not known	2	2	1	4	1	2	1	2
Total	100	100	100	100	100	100	100	100
Base: Informants on NHS prescribing lists who consulted GP in year previous to survey								
Weighted for age	224	279	222	222	237	179	91	1454
Unweighted for age	224	279	222	222	237	357	182	1723

Table 12.7 Number of occasions on which written prescriptions received in year prior to survey, by age and sex

Number of occasions received written prescriptions	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
None	46	42	46	43	29	32	26	40
1 only	26	19	19	15	14	11	9	17
2-3	15	22	18	16	16	18	9	17
4-5	4	10	5	6	13	10	8	8
6-10	5	2	6	10	14	10	13	8
More than 10	1	3	5	10	14	18	30	9
Not known/not registered	3	2	2	1	1	2	4	2
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	170	203	160	177	156	121	47	1034
Unweighted for age	170	203	160	177	156	242	93	1200
Females								
None	16	18	24	32	27	25	27	24
1 only	18	17	17	16	13	8	6	14
2-3	35	27	30	18	18	8	8	22
4-5	14	9	11	12	7	11	9	10
6-10	11	16	5	9	10	18	13	11
More than 10	5	11	13	12	24	27	34	17
Not known/not registered	2	2	1	—	2	2	2	2
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	154	192	187	184	176	150	87	1130
Unweighted for age	154	192	187	184	176	300	174	1368
Persons								
None	32	30	34	37	28	28	27	31
1 only	22	18	18	15	13	9	7	16
2-3	24	25	24	17	17	13	8	20
4-5	9	10	8	9	10	10	9	9
6-10	8	9	5	9	12	15	13	10
More than 10	3	7	9	11	19	23	33	13
Not known/not registered	2	2	1	1	2	2	3	2
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	324	396	347	362	332	271	134	2169
Unweighted for age	324	396	347	362	332	542	268	2574

Table 12.8 Number of occasions on which prescriptions received in year prior to the survey, by social class

Number of occasions on which written prescriptions received	Non-manual	Manual		Total
	I, II, IIIM	IIIM	IV, V	
	%	%	%	%
None	34	29	29	31
1 only	17	16	14	16
2-3	20	22	18	20
4-5	8	11	9	9
6 or more	19	22	28	22
Not known/not registered	2	1	1	2
Total	100	100	100	100
Base: Weighted for age	833	739	508	2169
Unweighted for age	981	846	627	2574

Amongst those under 65, men were less likely than women to take their own prescriptions to a chemist. It seems that this was largely accounted for by the fact that they were at work during the day, since over two thirds said it was simply more convenient for someone else to go to a chemist for them, often mentioning their own working hours or insufficient free time as a reason for this.

We see in the next chapter how patients viewed the ease of access to their nearest pharmacy, but it should be noted at this stage that location did not appear to be a major reason for asking someone else to take prescriptions to a chemist. Although it was mentioned by one fifth of the group who usually had prescriptions taken for them, this was often because it was easier for another member of the family to get there than because

the nearest pharmacy was at any great distance from their home.

There are two further points which need to be mentioned before considering the location and accessibility of pharmacies. The first is that over 80% of patients who had been given prescriptions had, on the last occasion, received it in person at their doctor's surgery and relatively few had been given them at home (10%) or had someone else collect it (3%). Related to this is the siting of the pharmacy which patients usually used to get a prescription dispensed. It can be seen from the distribution below that patients are, on the whole, more likely to go to a pharmacy near the surgery than one near home, although as we see from later evidence, the relative distances involved are not, on the whole, very great.

Table 12.9 Whether usually takes prescriptions to chemist him/herself by age, sex and mobility

	16-64		65 and over		Total
	Males	Females	Males	Females	
	%	%	%	%	%
Informant usually takes prescription to chemist	86	93	80	67	87
Someone else usually takes prescription for them	12	5	17	29	11
Depends on circumstances	2	2	3	4	2
Total	100	100	100	100	100
Base: Weighted for age	574	756	129	183	1644
Unweighted for age	574	756	258	366	1776
	Restricted mobility	Mobile	Restricted mobility	Mobile	Total
Informant usually takes prescription to chemist	66	92	28	88	87
Someone else usually takes prescription for them	34	7	69	11	11
Depends on circumstances	—	1	2	2	2
Total	100	100	100	100	100
Base: Informants who had a prescription to dispense in year prior to survey					
Weighted for age	44	1286	78	230	1644
Unweighted for age	44	1286	156	460	1776

Usual chemist near surgery 53%
 Usual chemist near home 27%
 Usual chemist not near home or surgery 8%
 No usual chemist 13%
 Base: Patients who themselves had taken prescription to chemist in year prior to survey
 Weighted for age 1282
 Unweighted for age 1480

12.4 Summary

In order to examine how the need for dispensing services varies amongst the population, respondents were asked about the number of occasions on which they had received prescriptions from their doctors in the preceding year. About 90% of those who had consulted their doctor in the period concerned said they had received at least one written prescription and three quarters of the sample had been given one on their last consultation. The number of prescriptions which patients receive is related to the number of consultations they make and hence groups such as the elderly and

younger women show the greatest need for dispensing services.

The majority (89%) of those who had had at least one prescription to dispense in the preceding year said they usually took prescriptions to the chemist's shop themselves. Not unexpectedly the group who usually asked someone else to go for them, contained a relatively high proportion of the elderly and those with restricted mobility.

Over 80% of respondents who had been given a prescription during the period concerned had, on the last occasion, received it in person at their doctor's surgery. Related to this, it was found that patients are, on the whole, more likely to go to a pharmacy near the surgery rather than one near home to get their prescriptions dispensed.

Reference

- ¹ Karen Dunnel and Ann Cartwright. *Medicine takers, prescribers and hoarders*. Routledge and Kegan Paul. 1972. p 28.

13 Location and accessibility of pharmacies

13.1 Location of pharmacies

In order to obtain a standard and comparable measure of the physical accessibility of pharmacies we took as the key indicator the distance of the nearest pharmacy from home. Although as we have seen this is not necessarily the pharmacy which patients always use (Chapter 12) this measure enabled us to compare the location of pharmacies in different areas and regions of the country. In all cases we relied on the people interviewed to estimate within specified mile bands, the distances involved. Checks carried out at the pilot stage showed an acceptable degree of accuracy in the information provided.

Table 13.1 shows the distance of the nearest pharmacy

Table 13.1 Distance of nearest pharmacy from home, by whether rural or non-rural area

Distance of nearest pharmacy from home	Rural	Non-rural	Total
	%	%	%
Less than 1 mile	34 (—)	81 (.)	70 (.)
1 mile but less than 2 miles	19 (11%)	15 (1%)	16 (4%)
2 miles but less than 5 miles	30 (30%)	2 (12%)	9 (27%)
5 miles or more	16 (44%)	..	4 (45%)
Not known	..	1	1
Total	100	100	100
Base: Weighted for age	515	1654	2169
Unweighted for age	614	1960	2574

Note: Figures in brackets represent a proportion of each group who said their doctor normally supplied drugs or medicines.

for people living in rural and non-rural areas and, as might be expected, the distances involved in the two types of area show substantial differences.

Over 80% of people living in non-rural areas said they had a pharmacy within one mile of their home compared with only a third of those in rural areas. In fact

the great majority of those living at a distance of two miles or more from their nearest pharmacy were country dwellers. More surprisingly, perhaps, less than half of this latter group said their doctors usually supplied drugs or medicines, the rest received written prescriptions when medication was required (Table 13.1).

Regional variations which occur in the location of pharmacies are shown in Table 13.2. It can be seen that while the overall picture is reasonably similar in the three countries of Great Britain, the situation is rather different in Northern Ireland where only half the informants had a pharmacy within one mile of home*. There is also some variation between regions within England, with people in the North and South East seemingly better served than in the Midlands or the South West.

We have seen that there are significant differences between rural and non-rural areas in the distances which people have to go to get to their nearest pharmacy and it is possible that regional variations in the accessibility of pharmacies may be only a reflection of the degree of rurality of the different areas of the country. But it can be seen from Table 13.3 that, while the distances involved are reasonably similar in non-rural areas, there are still some variations occurring in rural areas. Although the numbers involved are quite small, it does seem that people living in rural areas in Scotland are slightly better provided with pharmacies than those in other countries while, within England, the Northern rural districts show the highest proportion of people with a pharmacy within one mile of home.

* It should be noted that because of the small sample size in Northern Ireland, this figure is subject to greater variations than the corresponding figures for other countries (see Appendix A).

Table 13.2 Distance of nearest pharmacy from home, by region and country

Distance of nearest pharmacy from home	North	Midlands	South East	South West	England	Wales	Scotland	N Ireland	Total UK
	%	%	%	%	%	%	%	%	%
Less than 1 mile	75	62	77	62	70	66	73	50	70
1 mile but less than 2 miles	16	17	13	20	16	20	14	24	16
2 miles but less than 5 miles	6	13	5	13	9	10	8	19	9
5 miles or more	2	6	2	4	4	3	4	7	4
Not known	1	2	2	1	1	1	—	—	1
Total	100	100	100	100	100	100	100	100	100
Base: Weighted for age	532	466	528	282	1808	105	194	62	2169
Unweighted for age	635	548	629	336	2148	123	234	70	2574

Table 13.3 Distance of nearest pharmacy from home, by region and country for rural and non-rural areas

Distance of nearest pharmacy from home	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
Rural areas	%	%	%	%	%	%	%	%	%
Less than 1 mile	46	29	31	25	33	37	46	12	34
1 mile but less than 2 miles	24	12	21	17	18	24	14	35	19
2 miles but less than 5 miles	17	37	31	40	31	25	26	38	30
5 miles or more	12	21	15	16	16	11	14	15	16
Not known	1	—	—	1	—	—	—	—	—
Total	100	100	100	100	100	100	100	100	100
<i>Base: Those living in rural areas</i>									
—Weighted for age	104	135	84	76	399	32	54	30	515
—Unweighted for age	125	158	102	89	474	38	68	35	614
Non-rural areas									
Less than 1 mile	82	76	86	75	81	79	83	87	81
1 mile but less than 2 miles	14	19	12	21	15	18	14	13	15
2 miles but less than 5 miles	3	3	—	3	2	3	2	—	2
5 miles or more	—	—	—	—	—	—	1	—	—
Not known	—	1	1	1	1	—	—	—	1
Total	100	100	100	100	100	100	100	100	100
<i>Base: Those living in non-rural areas</i>									
—Weighted for age	427	332	445	206	1409	74	140	32	1654
—Unweighted for age	510	390	527	247	1674	85	166	35	1960

It is known that the rate of closures of pharmacies has varied between different regions and countries, as is shown in Table 13.4.

The ratio of pharmacies to the population was calculated for each region and country (Table 13.5).

Table 13.4 Closure rate of pharmacies 1974–76*, by region and country

Region/country	Number of pharmacies open		% loss on 1974 number
	December 1974	December 1976	
North	2899	2740	5.5
Midlands	1922	1865	3.0
South East	2966	2874	3.1
South West	1555	1487	4.4
England	9342	8966	4.0
Wales	735	695	5.4
Scotland	1215	1163	4.3
Northern Ireland	573	536	6.5
Total UK	11865	11360	4.2

* Compiled from health statistics for England, Wales, Scotland and Northern Ireland (1976).

Table 13.5 Number of pharmacies per 1000 persons (1976), by region and country

Region/country	Population estimates 1976 (thousands)	Number of pharmacies December 1976	Number of pharmacies per 100000 persons
North	13206	2740	21
Midlands	11519	1865	16
South East	13546	2874	21
South West	8080	1487	18
England	46351	8966	19
Wales	2767	695	25
Scotland	5205	1163	22
Northern Ireland	1528	536	35
Total UK	55861	11360	20

From this it can be seen that although Northern Ireland has seen the greatest loss of pharmacies in recent years, it still has a higher pharmacy to patient ratio than the other countries. Likewise, the Northern region which has had the highest rate of closures in England, still maintains one of the highest provisions *per capita* in the country.

The Pharmaceutical Society's Survey of Pharmacies 1974, (which covered GB) published in the Pharmaceutical Journal of 1.11.75, indicated that closures between 1970 and 1974 had not significantly affected the distribution of pharmacies between rural, urban and suburban areas (rural pharmacies 26% of total). There has not been a similar survey since. Most closures have been in areas where there are other pharmacies, so it is not likely that there has been a marked increase in difficulty of access. As will be shown shortly, even in rural areas only a minority find access difficult, but we do not know whether or not the proportion doing so has increased.

Using the very broad measure of pharmacy to population ratios, the varying provision in different areas of the UK is roughly reflected in the distances which people, and particularly those in rural areas, have to travel to their nearest pharmacy.

People living in the South East and North of England, in general have rather better access to pharmacies than in the Midlands or South West, although England as a whole shows a rather poorer situation than Scotland or Wales. In Northern Ireland, the very small sample size makes it difficult to draw any conclusions, but it does

seem likely that a rather different situation exists there. The pharmacy to patient ratio in Northern Ireland is higher than anywhere else in the UK although accessibility in rural areas would appear to be relatively poor. This however could well be accounted for by the fairly low population density of the country, the very high proportion of people living in rural areas and the distribution of pharmacies outside urban areas.

13.2 Patients' views on the accessibility of pharmacies

It is clear that proximity will be a major determinant of how the public view the accessibility of pharmacies but it is of interest to know the extent to which distance is seen as creating difficulties and whether other factors influence views on the availability of dispensing services. We asked informants to give an assessment of how easy it was for them to get to a chemist's shop from where they lived and about 90% said that it was very or fairly easy. Although, inevitably, access was seen as more difficult as distance increased, it is perhaps more

surprising that around two thirds of the patients with a pharmacy two miles or more away from home felt that it was comparatively easy for them to get to one. We have seen however that a high proportion of this group lived in rural areas (Table 13.1) and their views on accessibility are likely to be affected by expectations of the distances which they need to travel for various services. This seems to be confirmed by the fact that irrespective of the distance travelled, the majority of people in such areas felt they had relatively easy access to a pharmacy from home (Table 13.7).

Not unexpectedly, the age of the informant also affected views on the accessibility of the nearest pharmacy. It can be seen that whatever the distance from their home, a higher proportion of the elderly than of younger informants said access was difficult for them except where the distance is five miles or more (Table 13.8). In fact, just over half of the group who lived within two miles of a pharmacy but felt access was

Table 13.6 Assessment of accessibility, by distance of nearest pharmacy

Accessibility from home assessed as:	Nearest pharmacy:				Total	Proportion with dispensing doctor
	Less than 1 mile	1 mile less than 2	2 miles less than 5	5 miles or more		
	%	%	%	%		
Very easy	78	36	29	11	64	(2%)
Fairly easy	18	50	48	50	27	(9%)
Fairly difficult	2	8	15	15	4	(15%)
Very difficult	..	3	6	21	2	(30%)
Not known	..	..	..	1	1	—
Not asked: disabled or housebound	2	2	1	1	1	—
Total	100	100	100	100	100	
Base: Weighted for age	1511	350	193	83	2169	
Unweighted for age	1792	417	226	101	2574	

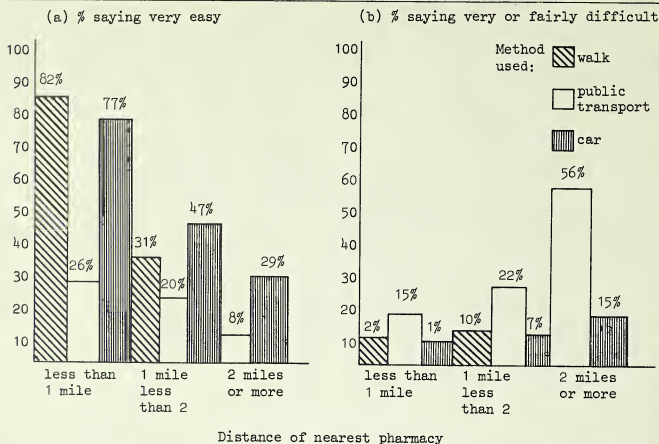
Table 13.7 Assessment of accessibility in rural and non-rural areas, by distance of nearest pharmacy

Accessibility from home assessed as:	Rural areas nearest pharmacy				Non-rural areas, nearest pharmacy		All rural areas	All non-rural areas	Total
	Less than 1 mile	1 mile less than 2	2 miles less than 5	5 miles or more	Less than 1 mile	1 mile or more			
	%	%	%	%	%	%			
Very easy	78	33	29	11	78	37	44	70	64
Fairly easy	19	56	49	50	18	47	40	23	27
Fairly difficult	2	8	14	15	2	10	9	3	4
Very difficult	..	3	6	20	..	4	6	1	2
Not known	..	..	..	3	..	..	1	1	1
Not asked: disabled or housebound	1	—	2	1	2	2	1	2	2
Total	100	100	100	100	100	100	100	100	100
Base: Weighted for age	172	98	157	81	1340	290	515	1654	2169
Unweighted for age	205	117	185	98	1586	342	614	1960	2574

Table 13.8 Assessment of accessibility, by age and distance of nearest pharmacy from home

Assessment of accessibility	Under 1 mile		1 mile less than 2 miles		2 miles less than 5 miles		5 miles or more		Total
	16-64	65+	16-64	65+	16-64	65+	16-64	65+	
	%	%	%	%	%	%	%	%	
Very easy	82	62	40	23	30	27	12	7	64
Fairly easy	16	26	51	49	50	37	49	52	27
Fairly or very difficult	1	5	10	19	21	28	36	35	6
Not known	..	..	..	2	..	5	3	1	1
Not asked: disabled or housebound	..	6	..	7	..	..	..	6	1
Total	100	100	100	100	100	100	100	100	100
Base: Weighted for age	1228	280	284	66	160	32	65	18	2169
Unweighted for age	1228	560	284	133	160	63	65	35	2574

Figure 13.1 Assessment of accessibility by distance and method of getting there



difficult, were informants who were elderly or had restricted mobility. A high proportion of this group said they usually had their prescriptions taken to a chemist for them.

The third factor which appeared to colour patients' views on the ease of access to a pharmacy from home was whether they had to use public transport to get there. Figure 13.1 shows that for all distances, those using public transport found access less easy than those using other means of travelling. This applied particularly to the elderly, who in any case tend to use public transport more than other groups. This is very similar to the situation found in the case of access to GPs (see Chapter 4).

The above evidence suggests that the majority of people in the country feel that they have reasonably easy access to a pharmacy from home, even though, in some cases, the distances involved are relatively great. It also seems that where difficulties of access do exist, they are as likely to be related to the mobility of the individual as they are to the location of the nearest pharmacy. It may be however that the accessibility of a pharmacy from home is not of the greatest importance, since as we have seen, a fairly sizeable proportion of people said they usually used a pharmacy near to their doctor's surgery. At this point, therefore, it is of interest to consider how the use of a pharmacy near to the surgery is related to

the proximity of one to home and generally how accessible these 'usual' chemists' shops are.

13.3 The 'usual' chemist

Questions about the siting of the chemist most frequently used for dispensing were addressed only to those who had taken at least one prescription to a pharmacy in the year prior to the survey. As might be expected, a rather lower proportion of those over 65 than of younger people fell in this category, the very elderly particularly showing a relatively high proportion who had not taken any of their prescriptions to a chemist themselves (Table 13.9(a)). However, amongst those who had taken at least one prescription, those over 65 showed a greater propensity to have a usual pharmacy (Table 13.9(b)). Amongst all age groups there was a greater tendency to use a pharmacy near to the surgery rather than one near to home although again, the elderly showed a greater likelihood of using one nearer home than younger people.

One particularly notable feature about the pharmacies which patients usually used was that over 90% were located within one mile of either home or the surgery. Virtually without exception, those who said their usual chemist's shop was near the surgery were talking about a pharmacy within one mile of the practice and a similar picture emerged for those who said their usual chemist

Table 13.9(a) Whether informants had taken prescription to be dispensed themselves (for those who had been given a prescription)

Had been given at least one prescription in year prior to survey and:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Males								
Had taken it to be dispensed themselves	86	91	89	89	89	90	77	88
Had not taken it to be dispensed themselves	14	9	11	11	11	10	23	12
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	96	134	107	118	120	92	36	703
Unweighted for age	96	134	107	118	120	184	72	831
Females								
Had taken it to be dispensed themselves	96	97	96	97	92	86	57	89
Had not taken it to be dispensed themselves	4	3	4	3	8	14	43	11
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	131	174	164	148	138	118	65	938
Unweighted for age	131	174	164	148	138	236	130	1122
Persons								
Had taken it to be dispensed themselves	92	94	93	93	91	88	64	89
Had not taken it to be dispensed themselves	8	6	7	7	9	12	36	11
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	227	308	270	266	258	210	101	1641
Unweighted for age	227	308	270	266	258	421	202	1952

Table 13.9(b) Whether informant had usual chemist, by age and sex (for those who had taken a prescription to be dispensed)

Had taken at least one prescription to be dispensed:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Males								
Usual chemist sited:								
near surgery	61	54	51	47	53	56	48	53
near home	18	21	29	29	25	28	32	26
not near either	4	4	4	5	7	5	10	5
Not known	7	2	3	2	—	2	7	2
No usual chemist	13	18	12	18	14	8	3	13
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	82	121	95	104	106	82	28	618
Unweighted for age	82	121	95	104	106	165	56	730
Females								
Usual chemist sited:								
near surgery	63	58	49	45	40	47	39	50
near home	15	22	29	29	34	36	43	29
not near either	6	4	9	12	15	10	12	10
Not known	—	2	1	1	1	3	1	1
No usual chemist	16	14	12	12	10	3	5	10
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	126	168	157	144	128	102	37	862
Unweighted for age	126	168	157	144	128	204	74	1002
Persons								
Usual chemist sited:								
near surgery	62	56	50	46	46	51	43	51
near home	16	21	29	29	30	33	38	28
not near either	5	4	7	9	11	8	11	8
Not known	1	2	2	2	—	3	4	2
No usual chemist	15	16	12	14	12	5	4	11
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	208	290	252	248	234	185	65	1482
Unweighted for age	208	290	252	248	234	370	130	1732

was near home (Table 13.10). To a large extent this is an artefact of the questioning since it is unlikely that distances over one mile will be considered as near. However, perhaps the most striking feature of the location of the usual pharmacy was that, irrespective of how the siting was described, the pharmacy referred to was, in the majority of cases, the nearest one to home

and in over three quarters of cases, within one mile of where the informants lived.

Not unexpectedly, the picture did differ a little between rural and non-rural areas (Table 13.11). There was, for example, a greater tendency in rural areas to use a pharmacy near to the surgery, irrespective of the

Table 13.10 Proximity of 'usual' chemist to home and surgery, by where 'usual' chemist sited

	Informants' description of siting of usual chemist	
	Near surgery	Near home
	%	%
Siting of 'usual' pharmacy in relation to home		
Less than 1 mile from home and nearest	44 } 55	84 } 93
but not nearest	11	8
1 mile less than 2 miles from home and nearest	13 } 26	5 } 6
but not nearest	13	2
2 miles or more from home and nearest	7 } 18	..
but not nearest	11	..
Total	100	100
Siting of 'usual' pharmacy in relation to surgery		
Less than 1 mile from surgery and nearest	88 } 99	Not asked
but not nearest	11	..
More than 1 mile from surgery and nearest	1 } 1	Not asked
but not nearest	1	..
Total	100	
<i>Base: Informants who had a 'usual' chemist</i>		
—Weighted for age	764	399
—Unweighted for age	886	484

distance of the nearest one from home. To some extent this will be a reflection of the siting of pharmacies in rural areas where the likelihood is they will be relatively near to medical practices. It is perhaps of interest to note that using a pharmacy sited near to a doctor's practice rarely involved patients travelling any greater

distance to get home than coming directly from the surgery.

The above evidence suggests that using a pharmacy sited near to the surgery is only, in part, related to the proximity of one to home, and that irrespective of the distance which people have to travel to their nearest chemist, they are more likely to use one sited nearer to the surgery. From this, we can conclude that in virtually all cases, for those who have a usual pharmacy, it will be sited within one mile of either home or the surgery and for the majority, the chemist's shop concerned will also be nearest to where they live.

13.4 Waiting time for prescriptions

In examining the accessibility of services available for dispensing prescriptions, we took the opportunity to review the amount of time which people generally have to wait for their medication once a prescription has been handed in. Although there was no evidence to suggest that lengthy waits were causing any problems, it was anticipated that if they did occur they might cause particular difficulty for those who lived at some distance from a pharmacy. We asked informants who had taken a prescription in the year prior to the survey how long they had waited for the drugs or medicines to be ready on the last occasion. As it is quite usual for people to hand in a prescription and call back when they know it will be ready, we were most concerned about whether the time it took caused any particular difficulty.

The evidence collected shows that not only were a very high proportion of prescriptions ready within 15

Table 13.11 Usual chemist, by distance of nearest pharmacy from home

	Under 1 mile	1 mile less than 2 miles	2 miles or more	Total
	%	%	%	%
All areas				
Usual chemist:				
near surgery	56	70	78	60
near home	38	12	1	31
not near either	6	19	21	9
Total	100	100	100	100
<i>Base: Informants with usual chemist</i>				
—Weighted for age	967	195	99	1276
—Unweighted for age	1145	232	113	1507
Rural areas				
Usual chemist:				
near surgery	71	74	79	74
near home	27	13	1	16
not near either	2	13	20	10
Total	100	100	100	100
<i>Base: Informants living in rural areas with usual chemist</i>				
—Weighted for age	109	57	80	252
—Unweighted for age	132	68	92	299
Non-rural areas				
Usual chemist:				
near surgery	54	68	(14)	56
near home	40	11	(5)	35
not near either	6	21	(5)	8
Total	100	100	100	100
<i>Base: Informants living in non-rural areas with usual chemist</i>				
—Weighted for age	858	138	18	1024
—Unweighted for age	1013	164	21	1208

minutes, but even if they did take longer, this rarely caused any problems for the person involved (Table 13.12). In addition, for the tiny minority who did ex-

Table 13.12 Time taken for prescription to be ready and whether any difficulties caused

Prescription ready in:	%	Proportion for whom this:	
		Caused difficulty	Caused no difficulty
5 minutes or less	36	—	—
Between 5 and 10 minutes	31	—	—
Between 10 and 15 minutes	12	—	—
Between 15 and 30 minutes	12	1%	11%
Between 30 minutes and 1 hour	2	1%	1%
Over 1 hour, but same day	1	—	1%
Collected next day	3	—	3%
Not known	3	—	—
Total	100	2%	16%

Base: Informants who had taken a prescription to a chemist's shop in the year prior to the survey

—Weighted for age 1482
—Unweighted for age 1732

perience some difficulty, there was no evidence to suggest this was particularly related to the accessibility of the pharmacy, and there were no differences between rural and non-rural areas in this respect. The kind of problems described were more concerned with the inconvenience caused by waiting in the shop, or having to make a second visit, than in the distance involved in getting to the pharmacy. It would seem, therefore, that difficulties caused by a long wait for a prescription are very much the exception, and the majority of people can expect their medication to be ready within a relatively short time of handing in the prescription.

13.5 Evening and out of hours dispensing

Although not all prescriptions given to patients need to be dispensed immediately, it is likely to be the case that many people will wish to obtain the drugs or medicines which have been prescribed fairly soon after seeing their doctor. In cases where patients have attended an evening surgery, this may mean finding a pharmacy which is open for late dispensing. Many pharmacies do stay open after six o'clock in the evening for precisely this purpose, and in most areas there is a rota system for late dispensing, details of which are displayed in chemists' shops and local newspapers. The rota system also provides for a pharmacy in each district to be open for dispensing for an hour on Sundays and public holidays. In very exceptional circumstances patients may wish to get a prescription dispensed either late in the evening or on a Sunday outside the rota hours. NHS terms of service do not require pharmacies to be open for dispensing outside normal rota hours, but some pharmacists will dispense prescriptions marked urgent by the doctor: information is held by doctors and the local police. General medical practitioners are required by their terms of service to supply any drugs needed for immediate treatment of a patient before a supply can be otherwise obtained.

We were interested to know the extent to which patients were aware of a pharmacy which operated late

dispensing services and also how well informed the public are about how to find a pharmacy which would be open outside normal hours. Just under two thirds of patients said they knew of a pharmacy where they could get a prescription dispensed at the end of the evening surgery, and only a slightly smaller proportion knew of one which would be open late in the evening or on a Sunday. People in rural areas showed slightly less awareness of pharmacies which would be open for late dispensing, although it appears that this is largely accounted for by the rather higher proportion of people with dispensing doctors who, as we have seen (Chapter 12), have rather less call for using pharmacies at all (Table 13.13).

Table 13.13 Knowledge about evening and out of hours dispensing, in rural and non-rural areas

	Rural areas	Non-rural areas	Total
	%	%	%
Knows of chemist open after evening surgery	54	65	62
Does not know of one open after evening surgery:			
but has dispensing doctor	10	—	3
does not have dispensing doctor	30	30	30
No evening surgery	3	1	1
Not known/not registered	3	3	3
Total	100	100	100
Knows of chemist open late in evening/on a Sunday	46	59	56
Does not know of chemist open out of hours:			
but has dispensing doctor	12	1	3
does not have dispensing doctor	39	37	37
Not known/not registered	3	3	3
Total	100	100	100
Base: Weighted for age	515	1654	2169
Unweighted for age	614	1960	2574

The extent to which patients knew of a pharmacy open after the evening surgery varied very little indeed with the time the surgery ended, even when this was after seven o'clock in the evening. Knowledge of pharmacies for late dispensing also appeared to be largely unrelated to the age or sex of the informant, although very young men and the very elderly were slightly more likely to say they did not know of any chemist where they could go.

There do however appear to be some differences between countries in the extent to which people knew of pharmacies open out of hours, the most marked variation occurring in Scotland (Table 13.14). Here, a relatively small proportion of people knew of a pharmacy which would be open after their doctor's surgery, particularly in rural areas, while a surprisingly high number in non-rural areas knew of one open late in the evening or on a Sunday. There were also indications that in Wales, people in rural areas were more likely to know of pharmacies open for late dispensing than those in such areas in other countries. While these variations could be just a reflection of the level of patients' knowledge, it is perhaps more likely that they are reflecting differences in out of hours dispensing services in the different countries.

Table 13.14 Knowledge about evening and out of hours dispensing, in rural and non-rural areas, by region and country

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Rural areas									
Knows of chemist open after evening surgery	63	55	43	55	55	79	38	50	54
Does not know of one open after evening surgery:									
but has dispensing doctor	8	10	22	12	12	5	6	—	10
does not have dispensing doctor	27	28	32	26	28	13	50	35	30
No evening surgery	—	5	—	1	2	—	3	14	3
Not known/not registered	2	3	2	6	3	3	2	2	3
Total	100	100	100	100	100	100	100	100	100
Knows of chemist open late in evening/on a Sunday	52	43	35	40	43	71	48	52	46
Does not know of chemist open after hours:									
but has dispensing doctor	8	12	24	15	14	5	6	—	12
does not have dispensing doctor	38	41	39	38	39	21	43	47	39
Not known/not registered	2	3	2	6	3	3	3	2	3
Total	100	100	100	100	100	100	100	100	100
<i>Base: Those living in rural areas:</i>									
—Weighted for age	104	135	84	76	399	32	54	30	515
—Unweighted for age	123	158	102	89	474	38	68	35	614
Non-rural areas									
Knows of chemist open after evening surgery	67	65	67	65	66	64	51	62	65
Does not know of one open after evening surgery:									
but has dispensing doctor	28	32	29	29	29	29	44	35	31
does not have dispensing doctor	1	1	—	1	1	3	1	—	1
No evening surgery	3	1	4	4	3	3	3	3	3
Not known/not registered	3	1	4	4	3	3	3	3	3
Total	100	100	100	100	100	100	100	100	100
Knows of chemist open late in evening/on a Sunday	64	55	59	51	58	58	71	57	59
Does not know of chemist open after hours:									
but has dispensing doctor	33	44	37	45	39	38	26	40	38
does not have dispensing doctor	3	1	4	4	3	4	3	3	3
Not known/not registered	3	1	4	4	3	4	3	3	3
Total	100	100	100	100	100	100	100	100	100
<i>Base: Those living in non-rural areas:</i>									
—Weighted for age	427	332	445	206	1409	74	140	32	1654
—Unweighted for age	510	390	527	247	1674	85	166	35	1960

Table 13.15 How informants would find pharmacy for late dispensing, in rural and non-rural areas

	After evening surgery		Late in evening/on Sunday		Total	
	Rural	Non-rural	Rural	Non-rural	After evening surgery	Late in evening on Sunday
	%	%	%	%	%	%
Look in newspaper	27	31	29	37	30	35
Look at list in chemist's window	13	19	12	19	17	17
Ask at surgery	16	21	20	15	20	17
Ask friend/relative	5	4	5	6	4	6
Ask police	6	4	6	6	4	6
Ask local health service	2	1	4	3	1	3
Ask hospital pharmacy	1	—	3	1	1	2
Call at local chemist and ask pharmacist to dispense prescription	2	1	2	2	1	2
Look around until found one	8	5	7	7	6	7
Wait until next day	7	7	1	7	7	2
Would not know what to do	25	17	21	13	19	16
Other answers	1	2	2	3	2	2
Total	100	100	100	100	100	100
<i>Base: Informants who did not know of a pharmacy open for late dispensing</i>						
—Weighted for age	192	529	247	636	721	882
—Unweighted for age	254	606	312	726	860	1038

We asked informants who did not know of a chemist which would be open, how they would find a pharmacy if they needed to get a prescription dispensed out of hours. As can be seen from Table 13.15, the majority of

people would either look in a newspaper, look at the times and locations displayed in chemists' windows, or ask at the surgery. There was however a fairly sizeable proportion (around one sixth) who said they would not

know what to do, and this was rather greater amongst people living in rural than in non-rural areas. It was also the case that the elderly and the youngest informants were less likely to know what to do than other age groups.

All of this suggests that patients are, in general, reasonably well informed about pharmacies offering out of hours dispensing and how to set about finding one should they need a prescription dispensed. The level of knowledge appears to be largely unrelated to the use of dispensing services but as we noted earlier, the public use pharmacies for a number of other purposes. It is possible therefore that the need for non-prescribed medicines or other health products outside normal shop hours has led to this generally high level of awareness of how to obtain medication.

13.6 Summary

The distance of the nearest pharmacy to home was used as the key indicator to examine the physical accessibility of pharmacies. Not unexpectedly, there was considerable variation between rural and non-rural areas in the proximity of the nearest pharmacy although 70% of the sample had one within one mile of where they lived. There was also some variation between regions and

countries in the distances which people travelled to their nearest pharmacy, with people in Scotland, Wales and the North and South East of England reporting rather easier access than those in other parts of the UK. It is suggested that the varying provision of pharmacies in different areas of the country is roughly reflected in the distances which people have to travel to their nearest chemist, particularly in rural areas.

It appears that the great majority of people in the country feel that they have reasonably easy access to a pharmacy from home although this varies between rural and non-rural areas because of the distances involved. It seems however that where difficulties of access do exist, they are as likely to be related to the mobility of the individual as they are to the location of the nearest pharmacy.

The majority of informants appeared to be reasonably well informed about pharmacies open for evening and out of hours dispensing, or about how to find such a pharmacy should they need one. As this appears to be unrelated to the use of dispensing services, the call for non-prescribed medicines or health products outside normal shop hours may have led to this generally high level of awareness of how to obtain medication.

14 Ophthalmic services

14.1 Introduction

Each year over 9,000,000 sight tests are given in the United Kingdom*, through the general ophthalmic services. These sight tests, which are free of charge to the patient, are carried out by ophthalmic opticians or ophthalmic medical practitioners[§], who, like doctors and dentists, enter into contracts with Family Practitioner Committees or Health Boards to provide the services required. Over 80% of the sight tests given result in spectacles being prescribed and in most cases patients will then be supplied with lenses, through the National Health Service. Although frames for spectacles can also be obtained through the National Health Service, it is quite usual for patients to obtain these on a private basis. The frames and lenses are supplied either by ophthalmic opticians, or by dispensing opticians who are authorised to fit lenses although not to carry out sight tests.

Amongst the adult population, two out of three people will have had lenses prescribed for them at some time* and although the number of sight tests given is well monitored by the Health Departments of the four countries of the UK little is known about patterns of attendance for ophthalmic treatment. It is, however, of interest to know more about the use of services amongst the population as a whole, partly to examine whether in general attendance for tests is sufficiently frequent for the correct level of lens prescription to be maintained but also to determine whether there are any deterrents to using ophthalmic services. Thus the main concerns of the present enquiry were to investigate the use of ophthalmic services, both for spectacle wearers and for those who had not had lenses prescribed and to examine the availability of these services within the community. The survey also provided an opportunity to determine the use and knowledge of domiciliary sight tests, which are carried out by some practitioners when patients cannot attend a practice themselves. In examining these areas we have been concerned only with the use of primary ophthalmic services and not with specialist services such as those provided in schools or hospitals.

14.2 Optical status and attendance for sight tests

Two thirds of the people interviewed said that they had, at some time, had glasses or lenses prescribed through the general ophthalmic services[†]. Although inevitably the proportion with prescribed lenses increased steadily

with age, the most substantial change occurred between the people aged 35 to 44 and 45 to 54. Amongst the latter group more than three quarters used spectacles or lenses (Table 14.1). Below this age a higher proportion of women than men had had lenses prescribed, but at 45 the proportions become very similar which is the result of a greater increase in lens wearing among men at this age than among women (See Figure 14.1).

Further evidence suggests that it is only amongst the under 45 age group that any significant variations in the level of lens wearing is likely to occur. There is for example, some variation in lens prescription with social class amongst this age group, with those in Groups IV and V showing lower proportions having lenses prescribed (Table 14.2). Similarly it would appear that there are slight differences between regions and countries in the extent to which lenses had been prescribed, but again these occurred only amongst those aged under 45 (Table 14.3).

It is well known that once people reach middle age, the chance of their having to wear spectacles or lenses, for at least part of the time, is high. It is possible, however, that the variation we have seen in the level of lens prescription amongst the younger population is purely a reflection of the extent to which certain groups choose to have their sight tested. This can be examined by looking at the incidence of lens prescription amongst those who had been for a sight test at some stage. An analysis of this by age and sex suggests that differences between men and women in the level of lens prescription, cannot be accounted for by a greater tendency amongst women to have their sight tested at an earlier age (Table 14.4). Amongst those under 35, for example, quite similar proportions of men and women had had their sight tested, but as a result of such tests approximately three quarters of the women had lenses prescribed compared with less than two thirds of the men. This would suggest that, in general, women may need to have their sight corrected at a younger age than men and are therefore likely to make greater use of the ophthalmic services.

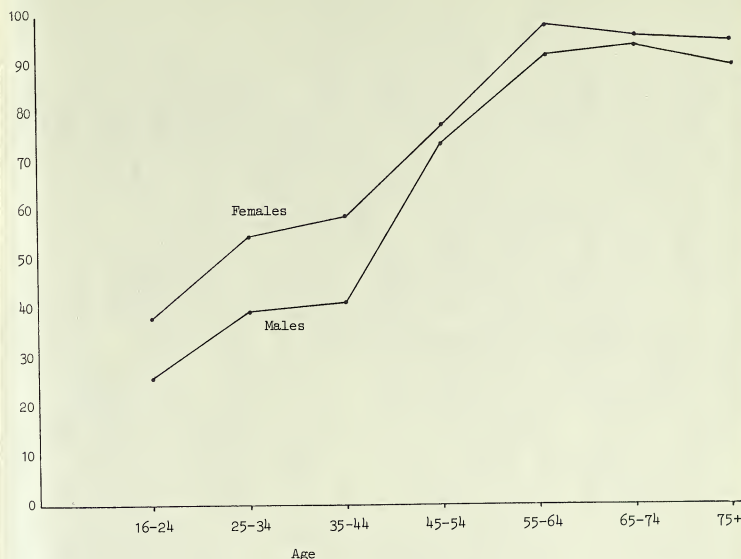
A rather different picture emerges, however, when we look at social class differences in attendance for sight tests (Table 14.5).

* Compiled from published health statistics for England, Wales, Scotland and Northern Ireland (1976).

§ Ophthalmic medical practitioners are doctors who test sight and prescribe optical appliances: ophthalmic opticians are qualified to test sight, prescribe and also supply optical appliances.

† Based on replies to the question 'Have you ever had glasses or contact lenses prescribed for you by an optician or a doctor, apart from at school or at a hospital?'

Figure 14.1 Proportion who had spectacles/lenses prescribed, by age and sex



Here the evidence suggests that people under 45 in the semi-skilled and unskilled groups are less likely to have their sight tested than those from other groups, but amongst those who have done so there are no significant differences between the proportions with prescribed lenses. It would seem, therefore, that the lower level of lens prescription amongst the lower social classes is a result of smaller proportions attending for sight tests rather than any differences in the extent to which lenses are prescribed for the different groups. Likewise, differences in Scotland and England in the level of lens prescription would appear to be a reflection of the slightly smaller proportion of younger people attending for tests in Scotland rather than any variation in the extent to which lenses are prescribed (Table 14.6). In this context, it is perhaps worth noting that there were no differences at all between rural and non-rural areas, either in the proportions who had had sight tests or in the extent to which lenses were prescribed.

It would seem therefore that while age and, to a lesser extent, sex are important factors in the level of lens

prescription within the population, other variations are likely to be accounted for by a greater propensity amongst certain groups to have their sight tested at an earlier age. It is also evident, however, that when people do go for a sight test, there is a relatively high probability that they will be in need of some sight correction. This leads us to consider the reasons why people go for sight tests in the first place and how non-lens wearers generally view the need to have their sight examined. It should be noted that, throughout the remainder of this chapter we have used the terms 'lens wearers' and 'non-lens wearers' to distinguish those who have had lenses prescribed from those who have not. It is recognised however that there will be some people in the former category who do not use the lenses or spectacles they have been prescribed.

14.3 Views about sight tests—non-lens wearers

Although there are no strict guidelines about the frequency with which non-lens wearers should have sight tests, it is considered advisable for people to have a test every five to 10 years, and rather more frequently as

Table 14.1 Whether had lenses prescribed, by age and sex

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Had spectacles/lenses prescribed	26	40	41	74	92	94	90	60
Not had lenses prescribed	74	60	59	26	7	6	7	40
Not known	—	—	—	—	1	—	3	..
Total	100	100	100	100	100	100	100	100
<i>Base: Weighted for age</i>	170	203	160	177	156	121	47	1034
<i>Unweighted for age</i>	170	203	160	177	156	242	93	1201
Females								
Had spectacles/lenses prescribed	38	53	59	78	98	96	95	72
Not had lenses prescribed	62	47	41	22	2	3	4	28
Not known	—	—	—	—	—	1	1	..
Total	100	100	100	100	100	100	100	100
<i>Base: Weighted for age</i>	154	192	187	184	176	150	87	1130
<i>Unweighted for age</i>	154	192	187	184	176	300	175	1368
Persons								
Had spectacles/lenses prescribed	32	46	50	76	95	95	94	66
Not had lenses prescribed	68	54	50	24	5	4	5	34
Not known	—	—	—	—	..	1	1	..
Total	100	100	100	100	100	100	100	100
<i>Base: Weighted for age</i>	324	395	347	361	332	271	134	2169
<i>Unweighted for age</i>	324	395	347	361	332	542	268	2574

Table 14.2 Whether had lenses prescribed, by social class and age

	Non-manual		Manual		Total
	I, II	III, IV, V	III, IV, V	IV, V	%
Age 16-44	%	%	%	%	%
Had lenses prescribed	47	44	44	39	43
Not	53	56	56	61	57
Total	100	100	100	100	100
<i>Base: 16-44</i>	323	84	416	214	1066
Age 45 and over					
Had lenses prescribed	90	91	86	90	89
Not	10	9	14	10	11
Total	100	100	100	100	100
<i>Base: 45 and over</i>	293	133	318	294	1099
<i>Weighted for age</i>	381	193	426	414	1502

Table 14.3 Whether had lenses prescribed, by region, country and age

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Age 16-44									
Had lenses prescribed	43	40	44	51	44	43	37	32	43
Not	57	60	56	49	56	57	63	68	57
Total	100	100	100	100	100	100	100	100	100
<i>Base: 16-44</i>	264	227	248	154	894	46	92	34	1066
Age 45 and over									
Had lenses prescribed	89	88	91	87	89	83	90	(25)	89
Not	11	12	8	13	11	16	9	(3)	11
Total	100	100	100	100	100	100	100	—	100
<i>Base: 45 and over</i>	266	237	280	127	910	59	101	28	1099
<i>Weighted for age</i>	368	318	381	181	1248	77	141	36	1502

age increases. Table 14.7 shows that just over two thirds of non-lens wearers, even of those in their 30s and early 40s, had never had a sight test and a very small proportion indeed (17%) had had one within the previous five years.

In practice, therefore, relatively few non-lens wearers do go for sight tests, but to what extent do they see a

need to do so? We asked people who had never had a sight test whether they felt they should go to have their eyes tested from time to time.

Well over half of those questioned about this said they did not feel there was a need to have their sight examined, and this varied very little with age or sex (Table 14.8). However, illuminating the earlier finding,

Table 14.4 Attendance for sight tests and proportion with lenses prescribed, by age and sex

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Had at least one sight test	48	62	62	84	95	95	95	74
Not had sight test outside school or hospital	52	38	38	16	5	5	5	26
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	170	203	160	177	156	121	47	1034
Unweighted for age	170	203	160	177	156	242	93	1201
Proportion of those who had sight tested with prescribed lenses	55	64	66	89	98	99	99	82
Base: Weighted for age	80	126	98	149	148	116	44	761
Unweighted for age	80	126	98	149	148	231	88	920
Females								
Had at least one sight test	54	64	72	83	99	98	97	80
Not had sight test outside school or hospital	46	36	28	17	1	2	3	20
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	154	192	187	184	176	150	87	1130
Unweighted for age	154	192	187	184	176	300	175	1368
Proportion of those who had sight tested with prescribed lenses	70	83	82	94	99	99	99	90
Base: Weighted for age	84	123	135	154	174	147	84	901
Unweighted for age	84	123	135	154	174	294	169	1133
Persons								
Had at least one sight test	51	63	67	84	97	97	96	77
Not had sight test outside school or hospital	49	37	33	16	3	3	4	23
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	324	395	347	361	332	271	134	2169
Unweighted for age	324	395	347	361	332	542	268	2574
Proportion of those who had sight tested with prescribed lenses	63	73	75	91	98	99	99	87
Base: Weighted for age	164	249	233	303	322	263	128	1669
Unweighted for age	164	249	233	303	322	525	257	2056

§Informants who had been for sight test.

Table 14.5 Attendance for sight tests and proportion with lenses prescribed, by social class and age

	Non-manual		Manual		Total
	I, II	IIINM	IIIM	IV, V	
	%	%	%	%	%
Proportion who had at least one sight test					
16-44	66	62	61	52	61
45 or over	93	95	91	93	92
Base: 16-44	323	84	416	214	1066
45 and over: Weighted for age	293	133	318	294	1099
Unweighted for age	381	193	426	414	1502
Proportion of those who had sight tested with prescribed lenses					
16-44	71	71	71	76	71
45 or over	97	96	94	97	96
Base: Informants who had had sight test					
16-44	213	52	255	111	648
45 and over: Weighted for age	270	126	290	272	1015
Unweighted for age	358	180	376	376	1364

there was some variation with social class, a rather higher proportion of Groups III, IV and V than of others saying they saw no need for sight checks (Table 14.9).

Amongst those who felt they should have occasional tests (but had never done so), very few indeed could give

any specific reason why they had not been for one, other than the obvious one that they had not had any difficulty with their sight (Table 14.10). Even the cost of having glasses or lenses does not seem to be an important deterrent, being mentioned by only 2% of those questioned. Although the circumstances are rather different, these answers are in marked contrast to the

Table 14.6 Attendance for sight tests and proportion with lenses prescribed by region, country and age

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Proportion aged 16-44 who had at least one sight test	61	59	64	66	62	55	54	50	61
Base: Informants aged 16-44	265	227	248	154	894	46	184	34	1066
Proportion of those aged 16-44 who had sight tested with prescribed lenses	71	69	69	78	71	(20)	69	(11)	71
Base: Informants aged 16-44 who had sight test	162	134	159	101	556	(25)	99	(17)	648

Table 14.7 Length of time since last test, by age and sex. (Non-lens wearers)

	Males					Females					Persons				
	16-24	25-34	35-44	45 and over	Total	16-24	25-34	35-44	45 and over	Total	16-24	25-34	35-44	45 and over	Total
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Had sight test:															
within previous 2 years	14	12	9	12	12	16	8	4	4	9	15	10	7	8	10
2 years up to 5 years ago	6	10	4	5	6	4	7	14	8	8	5	8	8	6	7
5 years ago or more	9	15	22	17	15	7	9	15	16	11	8	12	18	19	13
Never had sight test	71	63	65	67	67	73	76	68	72	72	72	70	67	69	70
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Base: Informants who had not had lenses prescribed															
Weighted for age	125	122	95	67	409	96	91	77	52	316	221	212	172	119	728
Unweighted for age	125	122	95	77	419	96	91	77	61	325	221	212	172	138	746

Table 14.8 Views about need for sight tests, by age and sex. (Non-lens wearers)

	Males					Females					Persons				
	16-24	25-34	35-44	45 and over	Total	16-24	25-34	35-44	45 and over	Total	16-24	25-34	35-44	45 and over	Total
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Not had sight tested															
—but feels should do so from time to time	30	26	22	37	28	32	30	25	40	31	31	27	23	38	29
—and feels no need to do so	40	37	42	29	38	42	46	43	32	42	41	41	43	31	40
Had sight tested at least once	29	37	36	34	34	27	24	32	28	27	28	31	34	31	31
Not known	1	—	—	—	..	—	1	—	—	..	..	1	—	—	..
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Base: Informants who had not had lenses prescribed															
Weighted for age	125	122	95	67	409	96	91	77	52	316	221	212	172	119	728
Unweighted for age	125	122	95	77	419	96	91	77	61	325	221	212	172	138	746

Table 14.9 Views about sight tests, by social class. (Non-lens wearers)

	Non-manual		Manual		Total
	I, II	IIINM	IIIM	IV, V	
	%	%	%	%	
Not had sight test, —but feels should do so from time to time	31	25	28	32	29
—and feels no need to do so	33	41	40	46	39
Had sight tested at least once	35	34	32	21	31
Not known	..	—	—	..	1
Total	100	100	100	100	100
Base: Informants who had not had lenses prescribed					
Weighted for age	199	58	282	158	728
Unweighted for age	202	59	288	167	746

Table 14.10 Reasons why informants had not been for sight tests. (Non-lens wearers)

	%
Nothing wrong with eyes/never need to	29
Too busy/too much effort	14
Does not want to wear glasses	2
Cost of glasses/lenses	2
Location inconvenient	1
Have to get doctor's note first	1
Has/had sight tested at school, through job, at hospital	6
No particular reason	45
Other answers	3
<i>Base: Those who felt should have sight test occasionally but had none</i>	
Weighted for age	213
Unweighted for age	217

reasons given for attendance for dental treatment, where the majority are quite explicit about their reasons for not having regular check ups (Chapter 16).

In general, it seems that non-lens wearers see little need for regular sight checks and this is further confirmed if we examine the reasons given by those who *had* been for a sight test. In this context there are two groups it is of interest to consider. First there are the people who do not, at present, wear lenses who have been for a sight examination and secondly there are the group who also have had one sight test only but who, as a result of that test, became a lens wearer. While this latter group are by no means the only people in the sample to become lens wearers at their first sight test, they do have the most recent experience of such an outcome occurring.

Questions about the most recent sight test were asked only of those who had had a test within the past five years.

Table 14.11 shows that amongst the non-lens wearers, very few people indeed had been for a test because they thought their eyes should be checked. Amongst those who became lens wearers at their first test, almost 90% had gone to an optician because of having difficulty with their sight or because the doctor had sent them for medical reasons.

Table 14.11 Reasons for having sight test among informants who had only one test

	People who have only had one sight test who:		Total
	Are non-lens wearers	Became lens wearers after test	
	%	%	%
Went for sight test because:			
having trouble with eyes/sight	41	79	55
part of general medical examination	42	1	24
sent by doctor for medical reasons	10	10	10
thought should have eyes checked	3	7	6
Other reasons	4	4	4
Total	100	100	100
<i>Base: Informants who had had only one test</i>			
Weighted for age	72	130	202
Unweighted for age	73	137	210

These findings suggest that non-lens wearers are unlikely to have their sight tested, other than as part of a general medical examination, until they experience some difficulty with their sight. Furthermore there is a high proportion of non-lens wearers who see no reason to have sight checks even at an age where a test would certainly be recommended. Given that a high proportion of the population do wear lenses and most individuals are likely to be conscious of any deterioration in their sight, this pattern of referral to the ophthalmic services may not be a cause for concern. However if more regular sight checks for non-lens wearers are considered desirable, there is clearly a need for more public information about recommended frequency of tests.

14.4 Patterns of attendance amongst lens wearers

Once a person has had lenses prescribed it is considered desirable to have a sight test at least once every two to five years, depending on the eye condition concerned. However as there is a tendency for sight to deteriorate more rapidly as age increases, patients are advised to have tests more frequently as they get older and certainly for people in their 50s and 60s tests would be recommended at least once every two years.

Table 14.12 shows the length of time that had elapsed since lens wearers in the sample last had their sight tested, analysed by age and sex. It can be seen that while four fifths of the lens wearers had a sight test within the five years prior to the survey, only half had done so within the previous two years. Of rather more consequence, however, there was a sizeable proportion of elderly people, particularly men, who had not had their sight tested for five years or more.

In order to examine whether, in practice, lens wearers do see the need for regular sight checks we asked those who had been for a test in the previous five years why they went on the last occasion. Here we have confined the analysis to lens wearers who were going for their second or subsequent test. It can be seen that less than half had been purely for a routine check and the over 65 age group were less likely than younger patients to have had a routine test on the last occasion.

The minority of lens wearers who had not had, or could not remember having, a sight test for five years or more prior to the survey were asked whether they felt they should have their eyes tested more frequently or not. This group were more or less equally divided between those who saw the need for more regular tests and those who felt they had their sight tested sufficiently frequently, and this seemed to be the case irrespective of age or sex (Table 14.14). For most of the informants who recognised a need for more frequent tests, the reason for not going to the optician appears to have been inertia or lack of motivation to do so, although the cost of spectacles and lenses was mentioned by one in six (Table 14.15).

These findings about attendance amongst lens wearers

Table 14.12 Length of time since last visit by age and sex. (Lens wearers)

Had sight test:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Within previous 2 years	69	55	60	62	59	44	36	55
2 years to 5 years ago	29	28	24	27	27	34	29	29
5 years ago or more	2	17	15	11	13	21	33	15
Not known/not remembered	—	—	2	—	1	1	2	1
Total	100	100	100	100	100	100	100	100
<i>Base: Informants who had lenses prescribed</i>								
Weighted for age	44	82	65	131	144	114	42	622
Unweighted for age	44	82	65	131	144	229	84	778
Females								
Within previous 2 years	74	43	45	59	55	53	39	52
2 years to 5 years ago	9	27	34	31	32	34	32	30
5 years ago or more	15	30	21	10	13	12	23	17
Not known/not remembered	2	—	—	—	—	1	6	1
Total	100	100	100	100	100	100	100	100
<i>Base: Informants who had lenses prescribed</i>								
Weighted for age	58	102	110	144	172	144	83	813
Unweighted for age	58	102	110	144	172	288	166	1040
Persons								
Within previous 2 years	71	49	50	61	57	49	38	53
2 years to 5 years ago	18	27	30	29	30	34	31	29
5 years ago or more	10	24	19	10	13	16	26	16
Not known/not remembered	1	—	1	—	—	1	5	2
Total	100	100	100	100	100	100	100	100
<i>Base: Informants who had lenses prescribed</i>								
Weighted for age	103	183	175	275	316	258	125	1437
Unweighted for age	103	183	175	275	316	516	250	1821

Table 14.13 Reasons for having last sight test by age, among people who had more than one test. (Lens wearers)

Informant went for last sight test because:	16-64	65 and over	Total
	%	%	%
Due for sight test/thought should have eyes checked	49	42	45
Having trouble with eyes	36	40	36
To have frames/lenses repaired or replaced	12	15	13
Sent by doctor for medical reasons (eg headaches)	3	1	2
Part of general medical examination	—	—	1
Other reasons	2	3	2
<i>Base: Lens wearers who had more than one test</i>			
Weighted for age	738	282	1055
Unweighted for age	738	564	1304

suggest that while the majority do attend for sight tests at reasonably regular intervals, attendance is generally not as frequent as would be recommended, particularly amongst the elderly. Furthermore, on the evidence of the most recent test, it would seem that while a sizeable proportion (approaching half) of lens wearers do have their eyes checked as a matter of routine, there are as many who go for tests only when they need to have their spectacles repaired or replaced or when their sight has caused them some difficulty. This, again, tends to occur most amongst those aged over 65 when regular checks would be most advisable.

14.5 Type and location of practice attended

Over 80% of sight tests in England, and over 90% in other parts of the UK, are given by ophthalmic opticians while approximately one in 10 are carried out by

ophthalmic medical practitioners*. In common with pharmacists, but unlike other health practitioners, most opticians operate from 'shop' premises, usually sited in high streets or amongst other shopping and community facilities. In various parts of the country some dispensing opticians' premises, where ophthalmic medical practitioners are based, are known as eye centres. Any person wishing to use ophthalmic services is, in general, free to consult any ophthalmic optician or practitioner he or she chooses. Prior to 1978 the first sight test received had to be authorised by a medical practitioner.

There was interest in this enquiry to examine the type and location of the practice attended, but in particular, the reason why a particular practice was chosen. We therefore began by asking informants who had a sight test in the five years prior to the survey where they had been for their last test and whether it had been given by an optician or a doctor 'who specialises in examining eyes'.

Table 14.16 shows that over 90% of informants said their last sight test had been given by an optician, mostly at an ordinary practice, while 4% said that it was a specialist doctor who had tested their sight. It is clear, however, that it would have been difficult for many informants to distinguish opticians from ophthalmic medical practitioners and sight tests from specialist doctors are therefore likely to be under represented.

* Compiled from published health statistics for England, Wales, Scotland and Northern Ireland (1976).

Table 14.14 Views about frequency of attendance for sight tests, by age and sex. (Lens wearers)

	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
	%	%	%	%	%	%	%	%
Males								
Not had sight test for 5 years or more:								
—but feels should go more often	2	9	8	6	8	11	8	8
—and feels goes often enough	—	9	8	3	5	10	26	7
Had sight tested within previous 5 years	98	83	84	91	87	79	66	85
Total	100	100	100	100	100	100	100	100
Base: Male lens wearers								
Weighted for age	44	82	65	131	144	114	42	622
Unweighted for age	44	82	65	131	144	228	84	778
Females								
Not had sight test for 5 years or more:								
—but feels should go more often	7	17	14	4	6	11	8	9
—and feels goes often enough	9	13	8	5	7	10	18	8
Had sight tested within previous 5 years	84	70	79	90	87	79	74	83
Total	100	100	100	100	100	100	100	100
Base: Female lens wearers								
Weighted for age	58	102	110	144	172	144	83	813
Unweighted for age	58	102	110	144	172	288	166	1040
Persons								
Not had sight test for 5 years or more:								
—but feels should go more often	5	13	11	5	7	9	8	8
—and feels goes often enough	5	11	8	4	6	7	21	8
Had sight tested within previous 5 years	90	76	81	91	87	84	71	84
Total	100	100	100	100	100	100	100	100
Base: Female lens wearers								
Weighted for age	103	183	175	272	316	258	125	1437
Unweighted for age	103	183	175	275	316	516	250	1820

Table 14.15 Reasons for not having sight tested more frequently. (Lens wearers)

	%
Too busy, too much effort	45
No trouble with eyes or spectacles, not needed to	35
Cost of having glasses/lenses repaired or replaced	17
Location inconvenient	10
Difficulty getting an appointment	3
Had sight tested at hospital	2
No particular reason	7
Other answers	4
Base: Lens wearers who felt should have sight tested more frequently	
Weighted for age	119
Unweighted for age	153

A high proportion of the people who had lenses had been attending the same practice for some years and little more than a third had changed practices on the last occasion (Table 14.17).

In this context, it is appropriate to mention some subsidiary information collected about the use of reminders for tests. Those who had attended the same practice on more than one occasion were asked whether or not their optician sent a reminder when they were due to go for a sight test. Approximately one half of those who had lenses prescribed said that they usually received

Table 14.16 Type of practice attended for last test, by optical status

Last sight test given:	Lens wearers		Non-lens wearers	Total
	First test	Second or subsequent test		
	%	%	%	%
By an optician	(97)	(96)	(80)	(95)
at his/her practice	94	94	3	91
at a medical eye centre	2	—	—	2
at home	—	1	—	1
elsewhere (eg private eye clinic)	1	—	—	—
By a specialist doctor	(3)	(4)	(6)	(4)
at medical eye centre	1	1	2	1
elsewhere (eg own practice/surgery)	2	3	4	3
By own doctor/other GP	—	—	11	1
Not known	—	—	3	—
Total	100	100	100	100
Base: Informants who had sight test in previous 5 years				
Weighted for age	129	1022	69	1238
Unweighted for age	136	1304	71	1539

§Informants who had last sight test as part of a general medical examination have been excluded.

Table 14.17 Length of attendance at ophthalmic practice. (Lens wearers)

	%
Been attending same practice for:	
10 years or more	27
5 years up to 10 years	19
up to 5 years	15
Attended new practice on last occasion	38
Not known	1
Total	100
Base: Lens wearers who had sight test in previous 5 years	
Weighted for age	1185
Unweighted for age	1482

Table 14.18 Reminders for sight tests, by length of attendance at practice. (Lens wearers)

	Attended same practice for:			Total
	Up to 5 years	5 years up to 10 years	10 years or more	
	%	%	%	%
Optician sends reminder when sight test due	55	52	51	52
No reminder when sight test due	42	48	48	46
Not known	3	1	1	2
Total	100	100	100	100
Base: Lens wearers who attended same practice on more than one occasion				
Weighted for age	170	226	318	718
Unweighted for age	196	283	440	925

a reminder, although this varied very little with the length of time they had been attending that particular practice (Table 14.18).

In order to examine the factors which influence the choice of practice, we asked those who had had a sight test within the preceding five years why they chose the particular practice they attended last time*.

Table 14.19 shows that personal recommendation of friends or relatives had played an important part. However over one third said they had chosen the practice because it was the nearest or most convenient suggesting that physical accessibility is an important consideration. This makes it slightly surprising to find that the distances which people travelled, either from home or from work, for their last test were comparatively great, even in non-rural areas (Table 14.20).

For example a third of those living in non-rural areas travelled two miles or more for their most recent test and an even higher proportion in rural areas travelled five miles or more. These distances are somewhat greater than those presented previously for the other health services.

14.6 Domiciliary ophthalmic services

Under certain circumstances, opticians will visit patients in their own homes to carry out sight tests. Domiciliary

tests are usually given when the person concerned is unable to get to a practice, the very elderly in particular being an important group for such a service. The optician is entitled to charge the patient for the domiciliary visit, (although not for the test itself), as there is no facility for this service through the General Ophthalmic Services. However, the Hospital Eye Service will make a domiciliary visit at the request of a general medical practitioner. Previous evidence in this chapter (Table 14.16) has shown that less than 1% (0.3% of lens wearers) had their last sight test at home which gives a fairly clear indication of the extent to which domiciliary

Table 14.19 Factors affecting choice of practice by optical status

	Lens wearers	Non-lens wearers	Total
Chose practice because:	%	%	%
recommended by friends/relatives	48	40	47
recommended by health professional	6	16	6
nearest/most convenient experience/qualifications of practitioner	38	29	38
fewer disadvantages than others	2	—	2
No reason/can't remember	3	—	3
Other reasons	6	11	7
	7	11	8
Base: Informants who had sight test in previous 5 years			
Weighted for age	1151	69	1238
Unweighted for age	1440	71	1539

Table 14.20 Distance travelled from home/work for last sight test in rural and non-rural areas

	Rural areas	Non-rural areas	All areas
	%	%	%
Less than 1 mile	19	41	36
1 mile up to 2 miles	12	25	22
2 miles up to 5 miles	25	23	23
5 miles up to 10 miles	27	7	11
10 miles up to 20 miles	9	2	4
20 miles or more	4	1	2
Not known	3	2	2
Total	100	100	100
Base: Informants who had sight test in previous 5 years			
Weighted for age	263	972	1235
Unweighted for age	368	1243	1611

* Those who were attending the practice for the first time were asked 'what made you choose to go to that optician's practice to have your eyes tested?' Those who were attending the practice for the second or subsequent time were asked 'when you first went there, what made you choose to go to that optician's practice to have your eyes tested?'

services are provided. However the survey afforded an opportunity to explore the extent to which the public were aware that domiciliary sight tests could be made and the experiences of those who had attempted to arrange them.

In order to examine this we asked informants whether they, or any member of their family who was living with them at the time, had ever been given a sight test by an optician or a doctor at home, and if not whether they had ever tried to arrange one or knew it was possible to do so. It is evident from the information collected that domiciliary sight tests are an extremely rare occurrence, even amongst the elderly or those with restricted mobility (Tables 14.21 and 14.22). It can be seen that less than 1% of the sample had themselves had a sight test at home at any time, and only two people (0.1% of

the sample) said they or a member of their family had one in the year prior to the survey. The few informants who had experienced domiciliary sight tests, either for themselves or a relative, had, in a number of cases, been advised to arrange one by their family doctor or another health professional. None of this group said they had any difficulty in finding an optician willing to come, and indeed, some of the informants only knew domiciliary tests were possible because the optician concerned had volunteered to make the visit.

Table 14.21 Use and knowledge of domiciliary sight tests by age, sex and optical status

Table 14.21 Use and knowledge of domiciliary sight tests by age, sex and optical status									
	Lens wearers						Non-lens wearers		Total
	16-44		45-64		65 and over		All ages		
	Male	Female	Male	Female	Male	Female	Male	Female	
	%	%	%	%	%	%	%	%	
	%	%	%	%	%	%	%	%	
Informant had at least one sight test at home	—	..	..	1	..	2	—	—	..
Another member of family had sight test at home	1	1	1	1	..	1	..	..	1
Has tried unsuccessfully to arrange sight test at home	—	..	—	..	—	..	—	..	..
Knew sight tests at home were possible	12	16	17	20	13	16	9	8	13
Did not know sight tests at home were possible	87	83	82	78	86	81	90	91	85
Total	100	100	100	100	100	100	100	100	100
Base: Weighted for age	191	270	274	316	156	227	410	318	2169
Unweighted for age	191	270	274	316	313	454	419	325	2574

Table 14.22 Use and knowledge of domiciliary sight tests, by mobility

	Restricted mobility		Total
	%	%	%
Informant had at least one sight test at home	2	..	..
Another member of family had sight test at home	1	1	1
Has tried unsuccessfully to arrange sight test at home	—	..	..
Knew sight tests at home were possible	16	13	13
Did not know sight tests at home were possible	80	85	85
Total	100	100	100
Base: Weighted for age	138	2031	2169
Unweighted for age	229	2341	2574

Certainly there is no evidence from the survey to suggest that domiciliary visits are difficult to arrange, only four people (0.1%) of the sample, having ever attempted unsuccessfully to have a sight test at home.

The survey evidence suggests that the main reason why so few domiciliary sight tests are conducted may be that only a small minority know of their existence and hence requests for home visits are unlikely to be made. Even amongst those with restricted mobility, only a fifth were aware that sight tests at home were possible and yet all but 10% of this group had lenses prescribed. There does however seem to be some slight variation between countries in knowledge about home tests, with lens wearers in England showing a marginally lower level of awareness than elsewhere in the UK (Table 14.23).

Table 14.23 Use and knowledge of domiciliary sight tests, by country and optical status

	Lens wearers				Non-lens wearers				UK	
	England		Scotland	Northern Ireland	England		Scotland	Northern Ireland	Lens wearers	Non-lens wearers
	%	%	%	%	%	%	%	No	%	%
Informant had at least one sight test at home	1	1	1	—	—	—	—	—	1	—
Another member of family had sight test at home	1	2	..	3	..	—	—	—	1	..
Has tried unsuccessfully to have sight tests at home	..	1	—	—	..	—	—	—	..	..
Knew sight tests at home were possible	15	27	20	20	7	6	14	(5)	15	8
Did not know sight tests at home were possible	84	68	78	78	92	94	87	(21)	82	91
Total	100	100	100	100	100	100	100	—	100	100
Base: Weighted for age	1208	69	125	36	598	36	68	26	1437	728
Unweighted for age	1528	86	163	44	614	36	70	26	1821	746

We noted earlier that elderly people were amongst the more infrequent attenders for sight tests. One factor which may well be affecting this is the difficulty which some will have attending an ophthalmic practice, which as we have seen, may be at some distance from where they live. These findings suggest that, if recommended frequencies of tests are to be attained amongst the elderly, there may well be a need for domiciliary ophthalmic services to be more widely publicised, and possibly, made available under the general ophthalmic service.

14.7 Summary

Two thirds of the people interviewed said they had, at some time, had glasses or lenses prescribed through the general ophthalmic services. The proportion with prescribed lenses inevitably increased with age, the most marked difference occurring at 45 years or over. In each age group, but particularly amongst those under 45 years, a higher proportion of women than of men had had lenses prescribed. The survey evidence suggests that this may be accounted for by a greater need amongst women than amongst men to have their sight corrected at an earlier age rather than any differences between the sexes in attendance for sight tests. It does appear, however, that differences between social class groups and between countries in the level of lens prescription may well be accounted for by a greater propensity amongst certain groups to have their sight examined at a younger age.

The findings suggest that *non-lens* wearers are unlikely to have their sight tested until they experience some

difficulty with their sight. The majority of *lens wearers*, however, do attend for sight tests at reasonably regular intervals, although attendance is generally not as frequent as would be recommended particularly amongst the elderly. However, only about half the lens wearers had been for their last test as a matter of routine, the rest having been because they needed their spectacles repaired or replaced or because they were having difficulty with their sight. There is however no evidence from the survey to suggest any major deterrents to using the ophthalmic services.

Over two-thirds of lens wearers had attended the same optician's practice on more than one occasion, and many had attended the same practice for several years. The recommendation of friends or relatives played an important part in the patients' choice of practices, although over a third had chosen the practice because it was the nearest or most convenient. However, in general the distances which people had to travel to the practice, either from home or from work were comparatively great.

The survey evidence suggests that domiciliary sight tests are an extremely rare occurrence, with less than 1% of the respondents having had a sight test at home at any time. In addition only a minority of the people interviewed (15%) knew sight tests at home were possible, and this was true even amongst elderly people and those with restricted mobility. However, there is no evidence from the survey to suggest that if people do attempt to arrange a sight test at home, they will experience any difficulty in doing so.

15 Chiropody services

15.1 Introduction

National Health Service chiropody treatment is made available to members of the public through the community health services and the hospital services. The community service is restricted to four priority categories: the elderly, the handicapped, expectant mothers and school children. The hospital-based service is available as necessary to any hospital patient undergoing other treatment. Most NHS treatment is undertaken by chiropodists employed by Area Health Authorities or Health Boards, although some is provided by chiropodists from voluntary organisations acting on behalf of these bodies. Available statistics on the provision of NHS chiropody services show that the great majority of patients treated are aged 65 or over, although physically handicapped or otherwise disabled people under 65 also form an important group for such treatment. It is known however that many people in the country obtain private chiropody treatment outside the Community Health Services and a key area of investigation for the present survey was to examine the extent to which chiropody services are used and the characteristics of those receiving treatment. The survey has also examined the ways in which patients first started NHS or private chiropody treatment, the places at which patients receive treatment and the physical accessibility of their location.

15.2 Use of chiropody services

The extent to which chiropody services, both NHS and private, were used by the interview sample is shown in Table 15.1(a). It can be seen that 8% of informants had had chiropody treatment in the 12 months prior to the survey and a further 2% within the previous one to two years. Not unexpectedly, the proportions receiving treatment increased with age, the most marked differences occurring at 65 years and over. In all but the 25-34 age group, a higher proportion of women than of men had had treatment in the previous two years, the incidence being over twice as great amongst females.

Similar trends with age and sex are shown in patterns of attendance for chiropody treatment. Patients who had had treatment in the previous two years were asked whether they received treatment regularly or occasionally. (Although the pattern of attendance was defined by the patients themselves, over 90% of the regular attenders had had treatment within the previous six months compared with only one third of those who said they had treatment occasionally.) Table 15.1(b) shows that in the over 65 age group, the majority of patients had regular treatment, and in all age groups there were higher proportions of women than of men

receiving treatment regularly. In a survey carried out in 1976¹ among people aged 65 and over in England, it was found that 29% of women, compared with 18% of men, were unable to cut their own toenails and that this was not due to the higher average age of women: comparing age group with age group women were less likely than men to be able to cut their own toenails. There are, of course, other reasons for receiving chiropody treatment but it seems likely that people who are unable to cut their own toenails will also be unable to deal with other foot ailments. Physical disabilities (such as arthritis) may make it difficult or impossible to attend to one's own feet.

It is possible that differences between men's and women's shoe fashions lead to a greater need for foot treatment for women particularly among older people.

Amongst the elderly, the housebound and disabled were more likely than the mobile group to have had chiropody treatment in the last two years, and also to receive treatment regularly (Table 15.2). This was true, although to a lesser extent, for people with restricted mobility aged under 65. It is of interest to note however, that even with this higher incidence, a fairly sizeable proportion of those with restricted mobility had not received any treatment in the previous two years, even amongst the elderly.

For those aged 16-64, the extent of attendance for chiropody treatment appears to be much the same for all social classes (see Table 15.3). Amongst the elderly, however, people in the manual group were slightly less likely to have received chiropody treatment than those from other groups.

Table 15.4 suggests there is very little regional difference in attendance for chiropody treatment throughout the UK, although the proportion reporting attendance is marginally higher in Scotland than in England and Wales. There were no differences at all in attendance for treatment between rural and non-rural areas.

15.3 Use of NHS and private services

Informants who had had chiropody treatment in the two years prior to the survey were asked whether their last course of treatment had been obtained privately or through the NHS, and whether they usually, or always, had NHS or private treatment. Although no attempt was made to check the status of the treatment received, the patients did appear to be reasonably certain about NHS and private services. In addition, the proportion identified as having NHS treatment within the year

Table 15.1(a) Attendance for chiropody treatment, by age and sex

Has had chiropody treatment:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Within previous year	1	2	—	4	6	12	20	4
1 year but less than 2 years ago	3	..	1	—	2	2	2	1
No treatment in previous 2 years	96	98	99	96	91	86	78	94
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	170	203	160	177	156	121	47	1034
Unweighted for age	170	203	160	177	156	242	93	1200
Females								
Within previous year	3	2	8	6	16	32	37	13
1 year but less than 2 years ago	3	4	4	2	2	2	3	3
No treatment in previous 2 years	94	94	88	92	82	66	59	84
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	154	192	187	184	176	150	87	1130
Unweighted for age	154	192	187	184	176	300	174	1368
Persons								
Within previous year	2	2	4	5	11	23	31	9
1 year but less than 2 years ago	3	2	2	1	2	2	3	2
No treatment in previous 2 years	95	96	93	94	86	75	66	89
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	324	396	347	362	332	271	134	2169
Unweighted for age	324	396	347	362	332	542	268	2574

Table 15.1(b) Frequency of chiropody treatment, by age and sex

Has chiropody treatment:	16-24	25-34	35-44	45-54	55-64	65-74	75 and over	Total
Males	%	%	%	%	%	%	%	%
Regularly	—	1	—	2	3	8	17	3
Occasionally	4	1	1	2	6	6	5	3
No treatment in previous 2 years	96	98	99	96	91	86	78	94
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	170	203	160	177	156	121	47	1034
Unweighted for age	170	203	160	177	156	242	93	1200
Females								
Regularly	1	1	3	4	10	24	33	9
Occasionally	5	5	8	5	8	10	8	7
No treatment in previous 2 years	94	94	88	92	82	66	59	84
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	154	192	187	184	176	150	87	1130
Unweighted for age	154	192	187	184	176	300	174	1368
Persons								
Regularly	..	1	2	3	6	17	27	6
Occasionally	4	3	5	3	7	8	7	5
No treatment in previous 2 years	95	96	93	94	86	75	66	89
Total	100	100	100	100	100	100	100	100
Base: Weighted for age	324	396	347	362	332	271	134	2169
Unweighted for age	324	396	347	362	332	542	268	2574

Table 15.2 Attendance for chiropody treatment, by mobility

	16-64		65 and over		All ages		Total
	Restricted mobility	Mobile	Restricted mobility	Mobile	Restricted mobility	Mobile	
(a) Has had chiropody treatment:	%	%	%	%	%	%	%
within previous year	15	5	38	22	30	7	9
1 year but less than 2 years ago	2	2	2	3	2	2	2
no treatment in previous 2 years	83	93	61	75	68	91	89
Total	100	100	100	100	100	100	100
(b) Has chiropody treatment:							
regularly	7	2	32	17	24	4	6
occasionally	10	4	7	8	8	5	5
no treatment in previous 2 years	83	93	61	75	68	91	89
Total	100	100	100	100	100	100	100
Base: Weighted for age	47	1713	91	314	138	2027	2169
Unweighted for age	47	1713	182	628	229	2341	2574

Table 15.3 Attendance for chiropody treatment, by age and social class

Has had chiropody treatment:	16-64			65 and over			Total
	Non-manual I, II IIIM	Manual IIIM	IV, V	Non-manual I, II, IIIM	Manual IIIM	IV, V	
	%	%	%	%	%	%	%
Within previous year	5	3	6	30	24	21	9
1 year but less than 2 years ago	3	1	2	3	3	1	2
No treatment in previous 2 years	92	95	92	67	73	78	89
Total	100	100	100	100	100	100	100
Base: Weighted for age	684	627	388	148	108	119	2169
Unweighted for age	684	627	388	296	215	238	2574

Table 15.4 Attendance for chiropody treatment, by region and country

Has had chiropody treatment:	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Within previous year	10	8	7	8	8	9	11	10	9
1 year but less than 2 years ago	2	2	2	2	2	2	3	5	2
No treatment in previous 2 years	88	91	90	90	90	89	86	85	89
Total	100	100	100	100	100	100	100	100	100
Base: Weighted for age	532	466	528	282	1808	105	194	62	2169
Unweighted for age	635	548	629	336	2148	123	234	70	2574

Table 15.5 Use of NHS and private chiropody services, by age and sex

	16-64		65-74		75 and over		Persons		Total
	Male	Female	Male	Female	Male	Female	16-64	65 and over	
	%	%	%	%	%	%	%	%	%
Informant usually has:									
NHS chiropody treatment	1	1	7	17	19	22	1	15	44
Private chiropody treatment	3	9	7	18	5	18	6	13	7
No treatment in previous 2 years	96	90	86	65	75	59	93	71	89
Total	100	100	100	100	100	100	100	100	100
Base: Weighted for age	865	895	121	150	47	87	1760	405	2169
Unweighted for age	865	895	242	300	93	174	1760	810	2574

prior to the survey (4%) corresponds with official statistics about the number of persons receiving treatment through the Community Health Services*.

The following distribution shows that only one third of chiropody patients in the sample had had NHS treatment within the two year period concerned, the remaining two thirds having obtained treatment privately.

Only NHS treatment in previous two years	28
Usually private treatment but some NHS treatment in previous two years	3
Usually NHS treatment but some private treatment in previous two years	5
Only private treatment in previous two years	63
Total	100
Base: Informants who had chiropody treatment in previous two years	
—Weighted for age	236
—Unweighted for age	350

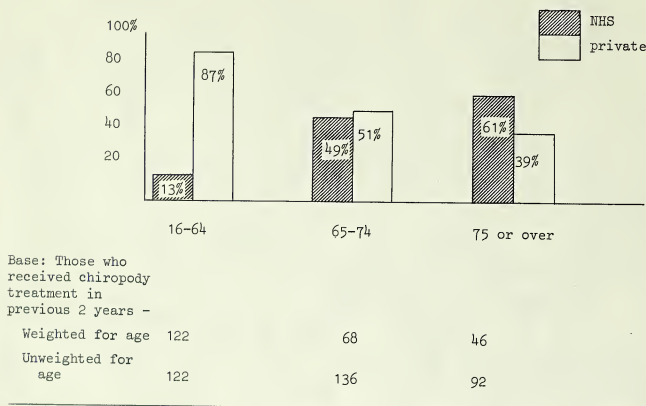
There also appeared to be very little interchange between private and NHS chiropody services, the vast majority of patients having had only NHS or only private treatment during the period concerned. For the subsequent analysis, therefore, we have considered the type of treatment usually obtained.

The extent to which NHS rather than private treatment has been obtained varied significantly with the age of the patient, as official statistics would suggest. Only 1% of people under 65 had had NHS treatment in the previous two years compared with 15% of those aged 65 or over (Table 15.5). Among people aged 75 or over, almost two thirds of those having chiropody treatment had done so through the National Health Service (Figure 15.1).

The use of NHS chiropody services was rather higher amongst women than men in the 65 to 74 age range, although such differences did not occur amongst the very elderly. Private treatment however was sought more frequently by women than by men in all age groups. It would seem therefore that a large part of the difference between men and women in the use of chiropody services is a result of the greater use of private services amongst women. This may be a reflection of the greater need for chiropody treatment amongst women, a need which cannot be met in full by the NHS services available.

* In 1976, over 1.5 million persons in the UK received chiropody treatment through the Community Health Services, representing approximately 3% of the population. (From published health statistics for England, Wales, Scotland and Northern Ireland—1976.)

Figure 15.1 Use of NHS and private chiropody services



As would be expected, a much higher proportion of the disabled and housebound group, than of those without some disability, had received NHS treatment (Table 15.6). It is notable however that only a quarter of the elderly with restricted mobility had received NHS chiropody treatment, although a further 15% had obtained some treatment through private services.

If we examine more closely the group who were receiving NHS treatment, we find it is comprised as shown in Table 15.7—approximately four-fifths of patients receiving NHS chiropody treatment were aged 65 or over, and more than a third had restricted mobility. Only a small proportion of the NHS patients were aged under 45, all of whom were fully mobile. The ratio of women to men receiving NHS treatment was approximately two to one, although this is largely

accounted for by the high number of very elderly women in the population who are the heaviest users of the chiropody services.

We saw earlier that among the 65 or over age group, where the need for chiropody treatment is greatest,

Table 15.7 Age, sex and mobility of those receiving NHS chiropody treatment

	%	Age 16-44	%	Restricted mobility	%
Male	34	45-64	14	35	
Female	66	65 or over	79	Mobile	65
Total	100		100		100
Base: Informants who usually have NHS chiropody treatment					
—Weighted for age	77		77		77
—Unweighted for age	138		138		138

Table 15.6 Use of NHS and private chiropody services, by mobility

	16-64		65 and over		All ages		Total
	Restricted mobility	Mobile	Restricted mobility	Mobile	Restricted mobility	Mobile	
Informant usually has:	%	%	%	%	%	%	%
NHS chiropody treatment	6	1	25	13	19	3	4
Private chiropody treatment	11	6	15	12	13	7	7
No treatment in previous 2 years	83	93	61	74	68	91	89
Total	100	100	100	100	100	100	100
Base: Weighted for age	47	1713	91	314	138	2027	2169
Unweighted for age	47	1713	182	628	229	2341	2574

those in the manual group were less likely to have had chiropody treatment than others. Table 15.8 suggests that this is largely accounted for by the more infrequent use of private services by this group than by any variation in the use of NHS treatment. It is of interest to note however that among those under 65, differences between social classes in the use of private services were very much less marked.

There were also some variations between countries in the use of NHS services, particularly amongst the elderly (Table 15.9). In England, for example, 14% of those aged 65 or over usually used NHS chiropody services compared with almost a quarter of the elderly in Scotland. In addition, in Wales and Scotland approximately half of those who received chiropody treatment in the period concerned had done so through the National Health Service while in England, over two-thirds of those having treatment used private services.

The figures presented in this section suggest that throughout the UK, but in England in particular, a major part of the demand for chiropody treatment^{*} is

being met through private services. Although those aged 65 or over, and those with some form of restricted mobility do use NHS services to a greater extent, there are still sizeable groups of such patients requiring treatment and seeking it through private services. In addition the less frequent use of private services by the elderly in the manual group suggests that there may well be an unmet need for chiropody treatment amongst them^{*}.

It is clear, however, that those receiving NHS treatment were far more likely to have treatment regularly than those who used the private services (Table 15.10). Over three quarters of NHS patients said they had regular chiropody treatment compared with less than half of the private patients. Among the elderly, where there is in any case a greater likelihood of receiving regular treatment, the differences between private and NHS services in patterns of attendance were just as marked.

* In *The elderly at home* (op cit) Audrey Hunt found that about 10% of those totally unable to cut their own toenails were receiving no help or inadequate help with the task.

Table 15.8 Use of NHS and private services, by age and social class

	16-64			65 and over			All ages		
	Non-manual		Manual	Non-manual		Manual	Non-manual		Manual
	I, II, IIIM	IIIM	IV, V	I, II, IIIM	IIIM	IV, V	I, II, IIIM	IIIM	IV, V
Informant usually has:	%	%	%	%	%	%	%	%	%
NHS chiropody treatment	1	...	2	14	17	14	3	3	5
Private chiropody treatment	8	4	5	19	9	7	10	5	5
No treatment in previous 2 years	92	95	92	67	73	78	87	92	89
Total	100	100	100	100	100	100	100	100	100
Base:									
Weighted for age	684	627	388	148	108	119	832	738	508
Unweighted for age	684	627	388	296	215	238	982	846	627

Table 15.9 Use of NHS and private services, by age and country

	All ages				65 and over			
	England	Wales	Scotland	N. Ireland	England	Wales	Scotland	N. Ireland
	%	%	%	%	%	%	%	%
Informant usually has:								
NHS chiropody treatment	3	6	7	3	14	20	24	No
Private chiropody treatment	7	5	7	11	13	10	10	(4)
No treatment in previous 2 years	90	89	86	85	72	70	66	(10)
Total	100	100	100	100	100	100	100	—
Base:	1808	105	194	62	339	18	40	8
Weighted for age	2148	123	234	70	678	36	79	17
Unweighted for age								

Table 15.10 Pattern of attendance for chiropody treatment, by whether NHS or private

	16-64	65 and over		All ages		Total
		NHS	Private	NHS	Private	
	%	%	%	%	%	
Informant has chiropody treatment:						
Regularly	34	86	56	78	41	53
Occasionally	66	14	44	22	59	47
Total	100	100	100	100	100	100
Base: Informants who had received chiropody treatment in previous 2 years						
Weighted for age	120	61	52	77	156	233
Unweighted for age	120	122	104	138	208	346

15.4 Referral for chiropody treatment

In examining the accessibility of chiropody services it was of interest to know how patients first started to go for treatment. Those who had had chiropody treatment in the two years prior to the survey were asked whether, when they first had chiropody, they themselves had decided they needed treatment or if someone else had suggested it. They were also asked whether they had made the arrangements for obtaining chiropody treatment, and if not, who had done so.

The information provided suggests that the extent of self-referral for chiropody treatment is high (Table 15.11). Two thirds of the patients who had used

Table 15.11 Referral for chiropody treatment by whether currently NHS or private patient

Referral:	NHS	Private	Total
	%	%	%
Initiated and arranged by patient themselves	45	79	67
Recommended and/or arranged by health professional	38	5	16
Recommended and/or arranged by friend/relative	16	16	16
Total	100	100	100
Base: Informants who had received chiropody treatment in previous 2 years			
—Weighted for age	77	156	233
—Unweighted for age	138	208	346

chiropody services in the previous two years said they themselves had both initiated and arranged for treatment when they first received it. Although the pattern is rather different for patients who currently used NHS services, almost half of this group had also referred themselves when they began having treatment. It is, of course, possible that some of these patients had used private services before they began receiving NHS treatment.

Not unexpectedly, elderly and disabled patients showed higher proportions having treatment recommended than other groups. In all age groups, however, women were more likely than men to have referred themselves for chiropody treatment.

Over a third of current NHS users and a small proportion of private patients said that treatment had been either recommended or arranged by a health professional. General practitioners were most frequently cited as having suggested, or arranged treatment although hospital doctors, district nurses and health visitors were amongst others mentioned.

Approximately two thirds of the patients who had arranged treatment themselves had used the personal recommendation of a friend or relative when setting about finding a chiropodist. Rather less frequently, others had sought advice from health professionals in the primary care services, or used the telephone directory or advertisements in newspapers as a source of information.

It would appear from the above evidence that referral for chiropody treatment, and information about chiropody services, is not, in most cases, obtained initially through local health services. Most of the group who had received treatment had found out about, and arranged, treatment themselves and only a small proportion had used formal channels for advice or information about where to go. While this may not be unexpected given the high proportion of patients using private services, it is perhaps more surprising that only 16% of those using chiropody services, representing less than 2% of the total sample, had begun chiropody treatment at the instigation of a health professional.

15.5 Usual place for treatment

Chiropody patients were asked where they usually received treatment, or, if they had no usual place, where they went for treatment on the last occasion. Private patients, almost without exception, said they usually attended a chiropodist's surgery or had treatment at home (Table 15.12). National Health patients, however, received treatment at a variety of places including health centres, hospitals, or local health or welfare clinics. The elderly were more likely than those in other age groups to have treatment at home, irrespective of whether they were private or NHS patients, with over a quarter saying they received domiciliary treatment.

Table 15.12 Place where chiropody treatment received by whether NHS or private treatment

Treatment received at:	All ages		65 and over		Total
	NHS	Private	NHS	Private	
	%	%	%	%	%
Chiropodist's surgery	21	76	21	71	61
Health centre	32	—	38	1	11
Local health/welfare clinic	10	—	10	—	3
Hospital	10	—	2	—	3
Home	21	17	25	28	18
Work	—	3	—	—	2
Other	6	1	3	1	2
Total	100	100	100	100	100
Base: Informants who had received chiropody treatment in previous 2 years					
—Weighted for age	77	156	61	52	233
—Unweighted for age	138	208	122	104	346

Table 15.13 Distance travelled for chiropody treatment, by type of place attended, and whether NHS or private

Distance travelled	(a) Chiropodist's surgery/shop		(b) Health centre, local clinic, hospital		Total	
	%	%	NHS patients	Private patients	%	%
Less than 1 mile	30	41	50	24	32	32
1 mile less than 2 miles	21	20	18	22	21	21
2 miles less than 5 miles	33	17	15	35	28	28
5 miles less than 10 miles	12	15	9	10	10	10
10 miles or more	5	2	5	8	7	7
Not known	—	4	2	1	1	1
Total	100	100	100	100	100	100
<i>Base: Informants who had chiropody treatment outside home on last occasion</i>						
—Weighted for age	141	47	61	129	190	190
—Unweighted for age	188	82	106	166	272	272

Those who had treatment outside their homes were asked how far they travelled to the clinic or surgery from where they lived (Table 15.13(a)). It can be seen that over a third of those using chiropody services travelled two or more miles, although those using specialist surgeries, on average, travelled further than those using health centres or clinics. These differences, together with the differential use of chiropodist's surgeries by NHS and private patients, result in a greater proportion of NHS patients travelling shorter distances for treatment than those using private services (15.13(b)).

15.6 Summary

Approximately one in 10 people interviewed had received chiropody treatment in the two years prior to the survey. There were marked differences in the use of

chiropody services with age, the greatest use occurring amongst those aged 65 or over. In all age groups, however, women used chiropody services more than men, the incidence being two to three times greater amongst females. Less than half the patients who received treatment had used NHS services, the rest having obtained treatment privately. The use of NHS services was greatest amongst those aged 65 or over, although even amongst this age group, a sizeable proportion used private services. It would appear that self-referral for chiropody treatment is usual, with two-thirds of the patients having both initiated and arranged treatment for themselves when they first received it.

References

- ¹ Audrey Hunt. *The elderly at home*. HMSO. 1978.
- ² CSO. *Annual Abstract of Statistics*, 1977. HMSO. 1977. pp 78-79.

16 Attendance for dental treatment

16.1 Introduction

National Health Service dentistry is provided largely by general dental practitioners, but also by the community dental services and by dental departments in hospitals. Community dental services are offered to pre-school and school children, and to pregnant and nursing mothers attending community health clinics. Access to treatment at a dental hospital is usually by referral from a dental practitioner, although patients may also present themselves at dental hospitals for emergency dental treatment.

The vast majority of people are treated by general dental practitioners. However, unlike general medical practitioners, dentists do not have a list of NHS patients for whom they are continually responsible. Instead, they enter into a contract with a patient only for a particular course of dental treatment, and when that treatment is completed neither dentist nor patient is under any obligation to renew the contract. In practice, of course, many patients do return to the same dentist for successive courses of treatment, and may therefore come to regard that dentist as 'theirs'.

Dentists who are under contract to provide NHS dentistry are not prohibited from also undertaking private treatment. They may, therefore, have patients whom they only treat privately, or they may undertake some courses of treatment on the NHS and others privately but are not permitted to undertake NHS and private treatments concurrently. One of the areas which the present survey has been concerned to examine is the availability of NHS dental treatment, as there is some evidence of difficulties in obtaining some dental treatment under the NHS, particularly in certain areas of the country.

The adult dental health survey carried out in 1968 examined dental health in England and Wales¹. In Scotland an adult dental survey was carried out in 1971 and the report was published in 1972². A follow-up UK survey³ has recently been undertaken. The basic aim of the follow-up is to provide comparative data about the level of dental health in the adult population, and the characteristics of the different dental status groups. The central concern of the present survey was to examine accessibility to NHS primary dental services and to consider the relationship between accessibility and dental attendance. However, since attendance is linked to the presence or absence of natural teeth it was also necessary to collect data concerning dental status ie presence or absence of natural teeth, based on informants' own statements. Presentation of results relating to this alone will, however, be kept to a minimum, as this area is examined in detail in the 1978 Adult Dental Health Survey.

As we explained earlier (Chapter 1), not all the sample was asked the full dental section. The elderly and one half of informants aged 16-64 were asked about dental status and attendance only. The other half of the sample aged 16-64 (2000 informants) were asked the full dental section which also covered NHS and private treatment, emergency treatment, access to a dentist, and reasons for choosing a particular dentist. Because of this, the bases in the tables vary depending on the analysis variables concerned.

16.2 Dental status

As previous survey work has shown, there were marked differences in dental status by age and sex (Table 16.1).

Table 16.1 Dental status by age and sex

Dental status	16-24	25-34	35-44	45-64	65 and over	Total
Males	%	%	%	%	%	%
Has some natural teeth	100	98	90	64	26	74
Lost all natural teeth	—	2	10	36	74	26
Total	100	100	100	100	100	100
Base:	332	396	318	635	336	2017
Females						
Has some natural teeth	99	96	84	56	20	66
Lost all natural teeth	1	4	16	44	80	34
Total	100	100	100	100	100	100
Base:	326	398	368	754	474	2320
Persons						
Has some natural teeth	100	97	87	60	23	70
Lost all natural teeth	—	3	13	40	77	30
Total	100	100	100	100	100	100
Base: All informants (UK)	658	794	686	1389	810	4343

Total tooth loss rose dramatically with age, and in every age group women were more likely than men to have lost all their natural teeth. There was a considerable social class gradient in total tooth loss, from 10% edentulous in Social Class I to 53% in Social Class V (Table 16.2). Substantial differences in the proportion of edentulous were also found by region (Table 16.3).

16.3 Dental attendance

The 1968 survey showed a very strong relationship between dental health and dental attendance patterns; in this survey we were concerned to identify the factors which are related to the frequency with which the population attend for dental treatment.

To establish dental attendance behaviour, informants who had some natural teeth were asked how long ago they last went to the dentist, and whether they considered that they went regularly, occasionally or only when having trouble with their teeth. People who had lost all their natural teeth were asked only how long ago they last went to the dentist.

Although dental attendance patterns were defined by patients themselves, evidence from the more detailed dental section shows that those who said they were

regular attenders were much more likely than irregular attenders to have been to the dentist recently (Table 16.4). In fact, virtually all of those who described themselves as regular attenders had been to the dentist in the last year, whereas a third of those who said that they went only when having trouble with their teeth had not been to the dentist in the last five years. Since it seems from this analysis that a person's own assessment is an accurate measure of his dental behaviour, we have used this variable in subsequent analyses of dental attendance for those individuals who had some natural teeth.

Tables 16.5 and 16.6 look at dental attendance patterns by age and sex for people with some natural teeth and the edentulous. In the former group, the elderly were more likely than those under 65 to go to the dentist only when having trouble with their teeth, and in all age groups, women were more likely than men to say that they went to the dentist regularly.

Among the edentulous, the elderly were less likely than those under 65 to have been to the dentist recently presumably because the length of time since total tooth loss increases with age, and for many people, their last series of visits to the dentist would have been those at

Table 16.2 Dental status by social class

Dental status	Non-manual			Manual			Total
	I	II	IIINM	IIIM	IV	V	
	%	%	%	%	%	%	%
Has some natural teeth	90	80	68	72	57	47	70
Lost all natural teeth	10	20	32	28	43	53	30
Total	100	100	100	100	100	100	100
Base: All informants (UK)	263	996	441	1482	710	251	4343

Table 16.3 Dental status by region and country

Dental status	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Has some natural teeth	65	69	77	78	72	64	58	70	70
Lost all natural teeth	35	32	23	22	28	36	42	30	30
Total	100	100	100	100	100	100	100	100	100
Base: All informants (UK)	1057	936	1067	568	3628	204	781	120	4343

Table 16.4 Length of time since last visit to dentist (those with some natural teeth)

Informant last went to the dentist:	Informant goes to the dentist:			Total
	Regularly	Occasionally	Only when trouble	
	%	%	%	%
Less than 6 months ago	80	23	12	45
6 months to 1 year ago	18	32	10	17
1 to 2 years ago	1	28	15	11
2 to 5 years ago	0	15	29	14
5 years ago or more	0	2	31	13
Can't remember	—	—	3	1
Total	100	100	100	100
Base§: 16-64 year olds with natural teeth (Sample B)	668	193	578	1442

§Excludes 1596 individuals who were asked abbreviated dental section.

which the last of their natural teeth were removed and dentures were fitted (Table 16.7).

Among those with some natural teeth, there was a marked social class gradient in dental attendance. People of higher social class were much more likely than those of lower social class to go to the dentist regularly. However, no such differences were found among the edentulous (Table 16.8).

By far the most striking regional differences in dental attendance were between England as a whole, and the

rest of the UK. In particular people living in Wales and Scotland were far more likely to go to the dentist only when having trouble with their teeth (Table 16.9).

Within England, people living in the North and Midlands were only slightly less likely than those in the South East and South West to go to the dentist regularly. This is interesting, in view of our previous finding that people living in the North, particularly, were considerably more likely than those in the South East and South West to have lost all their natural teeth.

Table 16.10 shows how the proportion of regular at-

Table 16.5 Dental attendance patterns by age and sex for informants with some natural teeth

Informant goes to dentist:	16-24	25-34	35-44	45-64	65 and over	Total
Males						
Regularly	37	42	42	35	18	38
Occasionally	14	13	14	12	4	13
Only when having trouble with teeth	49	45	44	53	78	49
Total	100	100	100	100	100	100
<i>Base: Male informants with some natural teeth</i>	331	386	286	408	88	1498
Females						
Regularly	54	57	48	46	34	50
Occasionally	13	15	16	15	8	14
Only when having trouble with teeth	32	28	36	39	58	36
Total	100	100	100	100	100	100
<i>Base: Female informants with some natural teeth</i>	324	384	312	420	94	1535
Persons						
Regularly	46	49	45	41	26	44
Occasionally	13	14	15	13	6	13
Only when having trouble with teeth	41	37	40	46	68	43
Total	100	100	100	100	100	100
<i>Base: All informants with some natural teeth</i>	655	769	598	829	182	3038

Table 16.6 Most recent visit to dentist for people with no natural teeth by age and sex

Most recent visit was:	Males				Females				Persons			
	16-44	45-64	65 and over	Total	16-44	45-64	65 and over	Total	16-44	45-64	65 and over	Total
	%	%	%		%	%	%		%	%	%	
Less than 2 yrs ago	37	20	13	18	30	20	13	17	32	20	13	18
2 yrs less than 5	26	20	8	15	21	23	16	20	23	22	13	18
5 yrs less than 10	22	23	17	20	25	26	14	20	24	25	15	20
10 yrs ago or more	15	37	62	47	24	31	57	43	21	33	59	44
Total	100	100	100	100	100	100	100	100	100	100	100	100
<i>Base: Informants with no natural teeth</i>	42	228	248	518	74	332	380	786	116	560	627	1306

Table 16.7 Number of years since lost last of natural teeth by length of time since last visited dentist

Last went to dentist:	Lost last of natural teeth			Total
	Less than 5 years ago	5 years less than 10	10 years ago or more	
	%	%	%	%
Less than 5 years ago	99	35	29	35
5 years less than 10	1	65	15	20
10 years ago or more	—	—	56	45
Total	100	100	100	100
<i>Base: Informants with no natural teeth</i>	111	160	1015	1306

Table 16.8 Dental attendance patterns by social class

	Non-manual			Manual			Total
	I	II	IIINM	IIIM	IV	V	
Informant goes to dentist:	%	%	%	%	%	%	%
regularly	70	55	51	36	30	27	44
occasionally	14	16	13	12	13	9	13
only when having trouble with teeth	16	30	36	52	56	64	42
Total	100	100	100	100	100	100	100
Base: Informants with some natural teeth	237	769	300	1065	402	117	3038
Most recent visit to dentist was:							
less than 2 years ago	(6)	19	19	18	17	15	18
2 years less than 5	(6)	20	18	18	17	16	18
5 years less than 10	(6)	18	17	22	22	20	20
10 years ago or more	(8)	43	46	42	44	48	45
Total	—	100	100	100	100	100	100
Base: Informants with no natural teeth	26	201	141	416	308	134	1306

Table 16.9 Dental attendance patterns by region and country

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
People with some natural teeth									
Informant goes to dentist:									
regularly	45	44	47	49	46	28	31	38	44
occasionally	10	13	16	12	13	17	14	17	13
only when having trouble with teeth	44	43	36	39	41	55	54	45	44
Total	100	100	100	100	100	100	100	100	100
Base: Informants with some natural teeth	688	641	826	440	2595	131	228	84	3038
People with no natural teeth									
Most recent visit was:									
less than 2 years ago	15	16	22	20	18	22	17	11	18
2 years less than 5	21	21	12	10	18	18	18	17	18
5 years less than 10	19	23	19	20	20	16	20	25	20
10 years ago or more	44	40	47	50	44	44	45	47	44
Total	100	100	100	100	100	100	100	100	100
Base: Informants with no natural teeth	369	295	241	128	1033	73	163	36	1306

Table 16.10 Proportion of regular attenders by region and country for people with natural teeth

	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	UK
Proportion of people with some natural teeth who attended dentist regularly									
Age									
16-44	49% (487)	46% (428)	50% (499)	51% (292)	49% (1706)	34% (87)	35% (337)	38% (60)	47% (2022)
45-64	36% (162)	44% (179)	46% (268)	46% (118)	44% (727)	16% (37)	22% (86)	19% (22)	41% (829)
Social class									
I, II	61% (243)	59% (200)	60% (297)	60% (168)	60% (908)	34% (47)	56% (95)	37% (30)	58% (1032)
III	40% (301)	40% (295)	41% (367)	45% (190)	41% (1153)	24% (58)	28% (253)	38% (34)	39% (1372)
IV, V	26% (119)	30% (123)	35% (130)	30% (67)	31% (439)	6% (23)	15% (85)	6% (15)	29% (520)
Area									
Rural	47% (137)	49% (186)	49% (127)	44% (125)	48% (575)	39% (41)	35% (130)	42% (41)	46% (722)
Non-rural	44% (551)	41% (455)	47% (699)	50% (315)	45% (2020)	23% (90)	35% (325)	43% (43)	43% (2316)

tenders varied with region for people of different ages, social class groups and the type of area in which they lived.

Among the edentulous, there were no marked regional differences in the length of time since informants last went to the dentist.

Differences in dental attendance were found by age, sex, social class and region, among individuals with some natural teeth. If accessibility to dental services affects attendance, then it ultimately influences dental health. We therefore need to explore the relationship between attendance and accessibility. Before doing so, however, it is worth considering patients' own views about their dental attendance patterns. It may, after all, be the case that individuals who go to the dentist infrequently simply do not perceive a need to go any more often.

16.4 Informants' views about dental attendance

Among the edentulous, the vast majority of individuals, even among those who had not been to the dentist for many years, thought that they went to the dentist often enough (Table 16.11). However, it is interesting that informants who did not say this were as likely to say that they did not know whether they should go more

often as they were to say that they ought to go more often. The percentage of edentulous who said that they did not know was much larger than the equivalent percentage of individuals with natural teeth. This would seem to reflect a degree of uncertainty among people with dentures about how often they need to go to the dentist (Table 16.11).

Among those with some natural teeth, informants seemed to be aware of the need to go to the dentist regularly, even if they themselves did not do so. Three quarters of those who went to the dentist occasionally or only when having trouble with their teeth said that they ought to go more often. Among those with natural teeth, there were also differences by age and sex, in the proportions saying that they ought to go to the dentist more often (Table 16.12). However, no such differences were found among the edentulous.

There were no marked differences by region or social class, in the proportions of people, either edentulous or with natural teeth, saying that they ought to go to the dentist more often. In view of the very large differences in attendance patterns by social class among those with some natural teeth, it is interesting that there are no differences in informants' views about how often they

Table 16.11 Informant's views about dental attendance, by dental attendance pattern

Informant thinks he/she:	Those with natural teeth			Edentulous				
	Informant goes to dentist:		Total	Informant last went to dentist:				Total
	Occasionally	Only when having trouble		Less than 2 years ago	2<5 years ago	5<10 years ago	10 years ago or more	
	%	%	%	%	%	%	%	%
Goes often enough	31	23	26	88	83	80	71	78
Ought to go more often	67	75	73	8	8	10	12	10
Doesn't know	2	1	1	4	8	9	16	11
Total	100	100	100	100	100	100	100	100
Weighted base:	408	149	1556	231	231	262	581	1306

Table 16.12 Informant's views about dental attendance by age and sex for people with some natural teeth

Informant thinks he/she:	16-24	25-34	35-44	45-64	65 and over	Total
	%	%	%	%	%	%
Males						
Goes often enough	20	17	31	30	58	27
Ought to go more often	79	82	66	68	41	71
Doesn't know	1	1	2	2	1	2
Total	100	100	100	100	100	100
Base: Male non-regular attenders with some natural teeth	187	208	154	241	60	850
Females						
Goes often enough	17	20	23	25	56	24
Ought to go more often	83	79	76	73	39	75
Doesn't know	—	1	1	2	5	1
Total	100	100	100	100	100	100
Base: Female non-regular attenders with some natural teeth	140	158	155	202	49	704
Persons						
Goes often enough	19	18	27	28	57	26
Ought to go more often	80	81	71	70	40	73
Doesn't know	1	1	2	2	3	1
Total	100	100	100	100	100	100
Base: All non-regular attenders with some natural teeth	328	367	308	442	109	1556

Table 16.13 Informant's views about dental attendance by social class for people with some natural teeth

Informant thinks he/she:	Non-manual			Manual			Total
	I	II	IIINM	IIIM	IV	V	
Goes often enough	28	25	30	24	26	24	26
Ought to go more often	70	74	68	74	72	74	73
Doesn't know	2	2	2	1	1	2	1
Total	100	100	100	100	100	100	100
Base: Non-regular attenders with some natural teeth	69	340	136	618	254	72	1556

Table 16.14 Reasons for not going to the dentist by dental status for people who never go or think they ought to go more often

*Reasons for not going to dentist	People with:		Total
	No natural teeth	Some natural teeth	
	%	%	%
Cost of treatment	24	6	8
Surgery hours inconvenient	2	8	7
Location of practice inconvenient	5	4	4
Other reasons relating to accessibility	5	4	4
Reasons unrelated to accessibility (eg laziness, too busy, fear)	65	81	79
Base: Informants who thought they ought to go to the dentist more often or had never been	134	1277	1409

§Some people gave more than one answer to this question.

ought to go. It does not seem that low attendance among those of lower social class is the result of a failure to recognise the need for regular treatment (Table 16.13).

16.5 Reasons why informants did not go to dentist more often

Informants who thought they ought to go to the dentist more often were asked their reasons for not doing so. We were most interested in reasons relating to accessibility of dental services, and have therefore presented reasons relating to different aspects of accessibility separately.

For the purposes of presentation, we have grouped together all other reasons, of which the most common were laziness and fear of going to the dentist.

The majority of informants gave reasons not related to accessibility (Table 16.14). However, among the edentulous, a quarter said the cost of treatment deterred them from going to the dentist compared with only 6% of people with natural teeth. As dental treatment for the edentulous (ie the supply of dentures) is substantially more expensive than treatment for people with natural teeth the fact that there is a difference is not surprising. The size of the difference is, however, slightly unexpected, particularly as we found no variation among people with natural teeth with respect to social class or age in the proportion of people who mentioned cost as a deterrent.

16.6 Summary

Among informants with no natural teeth nearly two thirds had not visited a dentist for five years or more. Sex differences were not very great but there was a sharp age gradient: three quarters of those aged 65 and over compared with just over half of those under 65 had not been to the dentist for five years or more.

Among informants with some natural teeth 44% described themselves as regular attenders at the dentists. These were much more likely than others to have seen a dentist within the past six months and this self-description has been used as the criterion of dental behaviour for people with some natural teeth, to whom the following paragraphs relate.

Women were more likely to be regular attenders than men and younger people than those aged 65 and over. However the 16-24 age group shows a slight divergence from the straightforward age trend.

The most marked differences, however, were those between social classes, where the percentage of regular attenders fell from 70% in Social Class I to 27% in Social Class V.

The highest proportion of regular attenders among countries was found in England (46%) and the lowest in Wales (28%). Regional differences in England were not very great. Slightly fewer regular attenders were found in the North and Midlands than in the South. Age and class differences were similar in all countries and regions.

Among those who described themselves as occasional attenders or attenders only when in trouble 73% said they thought they should go more often. Sex differences were small but there was a sharp fall with increasing age in the percentage who thought they ought to go more often. Perhaps surprisingly there was virtually no difference between the attitudes of the social classes.

Accessibility did not appear to be a major deterrent to regular attendance. Cost was important for the edentulous but the major group of reasons both for them and for those with natural teeth comprised those covering inertia and/or fear.

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17 The availability of NHS dental treatment and the accessibility of dental services

17.1 Introduction

In this chapter we investigate the availability of dental treatment under the National Health Service and the accessibility of dental services.

The figures presented in the following pages come from questions asked of a subsample of informants. As we have already explained, a few questions on dental status and dental attendance were asked of the whole sample while the more detailed questions concerning availability of NHS treatment and access to dental services were confined to one half of informants aged 16 to 64.

17.2 The availability of NHS dental treatment

We have noted in the previous chapter that one of the areas of interest in this survey was whether people had experienced any difficulty in obtaining dental treatment under the National Health Services since general practitioner dentists are not prohibited from undertaking treatment on a private basis nor are they compelled to treat people under the National Health Service.

The cost of treatment was one of the reasons given for infrequent dental attendance, and it is possible that this might reflect difficulties in obtaining NHS treatment and the need to pay for treatment to be done privately.

In order to examine the extent of private dental treatment, we asked patients who had been to the dentist in the last two years to describe their last course of treatment and to say whether or not they had had all NHS treatment, all private treatment or some of the treatment had been done under the NHS and some privately. Informants who had had all NHS treatment on the last occasion, or who had not been to the dentist in the last two years, were asked whether they had had any private dental treatment in the last five years. If the informant was at all uncertain about whether the treatment had been carried out under the NHS or privately the interviewers were asked to record the amount paid. Since the NHS charges are fixed according to treatment it was possible to check the amount paid against the treatment done and reliably estimate whether the treatment had been carried out on a private basis or under the NHS.

Among people who had received some treatment in the last five years 12% had had treatment privately during that time. The edentulous were slightly less likely than those with some natural teeth to have had private treatment (Table 17.1).

Table 17.1 Whether received private dental treatment in previous 5 years, by dental status

Informant received:	People with some natural teeth	Edentulous people	Total
	%	%	%
Some private treatment during last course (within previous 2 years)	8	5	8
Some private treatment in previous 5 years (but not at last course)	4	3	4
No private treatment in previous 5 years	84	88	84
Not known	4	4	4
Total	100	100	100
Base: Informants aged 16-64 who had been to the dentist in previous 5 years	1242	140	1382

Among people with natural teeth the proportion who had received some private treatment increased with age. It was not possible, however, to analyse the type of treatment by age because of the size of the groups.

There were no differences by the pattern of dental attendance in the proportions of people having private treatment nor did we find any difference in the proportions of people from different social classes who had had private treatment in the last five years. However, it should be remembered that the 1968 Adult Dental Health survey found that while there was no overall social class difference in the use of private treatment, there were differences in the type of treatment obtained. Whereas a very high proportion of people who had had conservative dentistry came from Social Classes I, II and III non-manual, private dentistry obtained by people from the other social classes was almost exclusively for extractions. Unfortunately, owing to small numbers, we were unable in the present survey to analyse the type of treatment obtained privately by social class.

There was however some variation between the regions in the proportion of people having private treatment; a higher proportion of people living in the South East were found to have had some private dental treatment during their last course of treatment than in any of the other regions.

It cannot be assumed, of course, that people who had private treatment did so from necessity—clearly, some people may prefer to have treatment done outside the NHS. Informants who had had private treatment in the last five years were asked whether they would have

Table 17.2 Whether received private dental treatment in previous 5 years, by age. (People with natural teeth)

Informant received:	16-24	25-34	35-44	45-64	Total
	%	%	%	%	%
Some private treatment during last course (within previous 2 years)	5	8	8	11	8
Some private treatment in previous 5 years (but not at last course)	3	4	6	4	4
No private treatment in previous 5 years	87	85	82	82	84
Not known	5	3	4	3	4
Total	100	100	100	100	100
Base: Informants aged 16-64 with natural teeth who had been to the dentist in previous 5 years	304	345	260	334	1242

Table 17.3 Whether received private dental treatment in previous 5 years, by region and country

Informant received:	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Some private treatment during last course (within previous 2 years)	5	8	12	7	8	7	4	5	8
Some private treatment in previous 5 years (but not at last course)	4	3	5	5	4	3	2	2	4
No private treatment in previous 5 years	88	85	78	86	84	86	93	86	84
Not known	3	4	5	2	4	3	1	7	4
Total	100	100	100	100	100	100	100	100	100
Base: Informants aged 16-64 who had been to the dentist in previous 5 years	319	298	361	187	1165	58	116	43	1382

preferred NHS treatment. Over a half said that they wanted private treatment. Thus, in overall terms, a very small proportion of people who had been to the dentist during the past five years had had private treatment when they would have preferred NHS treatment (Table 17.4).

Table 17.4 Experience of private treatment

Informant:	%
Had private treatment by choice	6
Had private treatment but would have preferred NHS	5
Had NHS only in last 5 years	84
Not known	4
Total	100
Base: Informants aged 16-64 who had been to the dentist in previous 5 years	1382

Informants who said they would have preferred NHS treatment were asked if they had asked the dentist to treat them as an NHS patient and if he had given them any reason why he could not. A half said they had asked and two thirds said he explained why he could not do the treatment under the NHS. The most common reason given was that the treatment was not available under the National Health Service.

People who had been treated privately in the two years previous to the survey were asked what treatment they

had done. Overall, we found that those whose treatment involved the crowning of teeth were more likely to have paid privately for their treatment than people who had other treatments. (Twenty per cent of people who had teeth crowned paid privately compared with 12% of people who had dentures fitted and 6% of people who had teeth filled.)

We have already seen that just under half of the people who had private treatment in the last five years would have preferred NHS treatment but the size of the group precludes further meaningful analysis in terms of the different types of treatment received by these people.

17.3 Dental practices attended

In order to examine physical access to dental services, informants were asked about the location of the practice they attended for their last course of treatment, and the distance they travelled to it. We were interested in the pattern of use of dental services, and therefore also asked informants whether the dental practice they went to last time was one they had been to before, and how they had set about choosing it.

Location of dental practice attended last time

Informants were asked to estimate the distance of the dental practice they went to last time either from home

(for those who went from home) or from work (for those who went from work). Over a third went to a dentist less than a mile away, and well over a half to one within two miles. However, 12% said that they went to a dentist five to 10 miles away and a further 5% that they went to one more than 10 miles away (Table 17.5).

We were concerned to know whether those people who did travel substantial distances to the dentist did so from choice or from necessity. We therefore asked all those informants who said that they travelled five or more miles to their dentist whether or not there was a dentist any nearer. Only a sixth of the sample estimated that they travelled five miles or more, and the great majority of them (three quarters) said that there was another dentist nearer than that one. Thus only 4% of the total sample travelled five or more miles to a dentist and did not have any dentist nearer to whom they could have gone instead. The ratio of dentist to population varies regionally, there being fewer dentists per head of population in the North than in the South. It has been argued that this is one of the factors accounting for the regional variation in dental health and behaviour. It might be supposed that in areas where there are fewer dentists, patients would have to travel further to them. However, when we examined regional differences in the distances patients travelled to the dentist, it was not the case that people living in the North travelled further. In fact, the reverse is true—a smaller proportion of patients in the North travelled five or more miles to the dentist than in any of the other regions. In fact, people in rural areas in the North fared particularly well compared with people living in rural areas in other parts of the country in terms of accessibility (Table 17.6). Just under a half of them travelled less than two miles to the dentist, whereas in the South East, for example, only a quarter of people living in rural areas travelled less than two miles. However, although a greater proportion of people in rural areas in the South East than in the North travelled five or more miles to the dentist, a greater proportion of the former group also knew of a dentist nearer.

Table 17.7 shows how far people travelled to their dentist according to their dental status and attendance pattern. Among people with natural teeth, regular attenders were more likely to travel further than others. There was very little difference however between the edentulous and people with natural teeth in the distance they travelled to the dentist.

Only a relatively small proportion of informants who travelled five miles or more to their dentist did not know of a dentist any nearer. This being so, what makes people choose to travel relatively long distances to go to a particular dentist? The reason most often given by informants who did so was that they liked their dentist and were satisfied with the treatment he gave (mentioned by 54% of informants). The next most often cited reason (given by 22% of the informants asked) was that the dentist had been recommended to them by relatives or friends. Other reasons given included dissatisfaction with nearer dentists (11%) and the fact that nearer dentists were unable to accept additional patients (7%).

17.4 Length of attendance at present dental practice

We wanted to know whether, on the whole, people tend to have a dentist they look on as 'their dentist', or whether they change dentists for each fresh course of treatment. Informants who had been to the dentist in the last five years were asked whether they had previously been to the dental practice where they had their last course of treatment, and if so, for how long they had been going to that practice. A surprisingly high proportion, over half the sample, had been going to the same dental practice for over five years. However, people who described themselves as regular attenders, were far more likely than others to have been to their present dental practice before (Table 17.8).

17.5 Choice of dental practice

The reasons given by informants for choosing a particular practice are listed in Table 17.9. The most common reason, given by over half the sample, was that

Table 17.5 Distance travelled to the dentist, by region and country

Distance travelled:	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
	%	%	%	%	%	%	%	%	%
Less than 1 mile	42	36	44	30	39	31	35	40	38
1 mile up to 2 miles	23	22	17	27	22	31	20	23	22
2 miles up to 5 miles	22	22	21	20	21	19	28	14	22
5 miles or more but there is a dentist nearer	10	12	14	16	12	10	10	12	13
5 miles or more no dentist nearer	2	6	3	4	4	9	5	12	4
Not known	1	2	1	3	2	—	2	—	2
Total	100	100	100	100	100	100	100	100	100
Base: Informants aged 16-64 who had been to the dentist in previous 5 years	319	298	361	187	1165	58	116	43	1382

Table 17.6 Distance travelled to the dentist, by region and country and type of area

Distance travelled:	North	Mid-lands	South East	South West	Eng-land	Wales	Scot-land	N Ire-land	Total UK
Rural areas	%	%	%	%	%	No.	%	No.	%
Less than 1 mile	28	24	16	19	22	(3)	22	(5)	22
1 mile up to 2 miles	17	12	9	8	12	(4)	13	(4)	13
2 miles up to 5 miles	27	25	34	17	26	(1)	29	(4)	25
5 miles or more: but there is a dentist nearer	15	20	25	34	22	(3)	16	(2)	21
5 miles or more: no dentist nearer	10	17	16	13	14	(4)	15	(4)	15
Not known	3	2	—	8	3	(—)	4	(—)	3
Total	100	100	100	100	100	100	100	100	100
Base: Those living in rural areas aged 16-64 who had been to the dentist in previous 5 years	60	87	56	47	250	15	34	19	318
Non-rural areas	%	%	%	%	%	%	%	No.	%
Less than 1 mile	45	41	49	34	44	35	40	(12)	43
1 mile up to 2 miles	24	26	19	33	24	33	23	(6)	24
2 miles up to 5 miles	21	20	18	21	20	23	28	(2)	21
5 miles or more: but there is a dentist nearer	8	9	12	10	10	7	7	(3)	10
5 miles or more: no dentist nearer	1	1	1	1	1	2	1	(1)	1
Not known	1	2	2	1	1	—	1	(—)	1
Total	100	100	100	100	100	100	100	100	100
Base: Those living in non-rural areas aged 16-64 who had been to the dentist in previous 5 years	259	211	305	140	915	43	82	24	1064

Table 17.7 Distance travelled to the dentist, by type of attender

Distance travelled	Those with natural teeth			Edentulous	Total
	Regular	Occasional	Only when trouble		
	%	%	%	%	%
Less than 1 mile	34	41	44	38	38
1 mile up to 2 miles	23	20	21	21	22
2 miles up to 5 miles	21	23	19	26	22
5 miles or more: but there is a dentist nearer	15	11	10	6	13
5 miles or more: no dentist nearer	5	2	3	7	4
Not known	1	2	2	1	2
Total	100	100	100	100	100
Base: Informants aged 16-64 who had been to the dentist in previous 5 years	666	190	383	140	1382

Table 17.8 Length of time at present dental practice by type of attender

Informant has been to present dentist:	Those with natural teeth			Edentulous	Total
	Regular	Occasional	Only when trouble		
	%	%	%	%	%
Once only	11	28	41	47	25
Before, for less than 5 years	28	22	14	9	22
Before, for 5 or more years	60	50	45	44	53
Total	100	100	100	100	100
Base: Informants aged 16-64 who had been to dentist in last 5 years	666	190	383	140	1382

Table 17.9 Reasons for choosing present dental practice

Reasons for choosing present dentist:	%
Dentist recommended by relatives/friends	58
Nearest/most convenient	38
Dentist had room on his books	4
Easy to get an appointment	3
Only dentist in area who would treat emergencies	3
NHS dentist	2
Informant wanted a particular treatment done	2
Dentist recommended by informant's doctor	2
Total	112
Base: Informants aged 16-64 who had been going to present dentist for up to 5 years	
	632

the practice had been recommended to them by relatives or friends. The second most common reason was that it was nearest, or most convenient to get to.

17.6 Future intentions

In addition to asking patients how long they had been going to their present dental practice, we asked if they intended to go back there for their next course of treatment. Over four fifths said that they intended to go back (Table 17.10) and, not surprisingly, the highest proportion of people who intended to return to their present dentist was found among the regular attenders. Among those who did not, the most common reason was that the location of their present dental practice was inconvenient (usually because either the patient himself or the dentist had moved). However, quite a high proportion of those who intended to change practices said they would do so because they were dissatisfied with the treatment they had been given, or that their dentist would not provide the treatment they required.

Overall then, it does seem that people show a marked loyalty to a particular dentist. They tend to return to the same one over and over again, and while not registered with him in the same way as they are registered with their GP, do tend to regard him as 'their' dentist.

17.7 Reminders

People who had been to their present dentist more than once, were asked whether or not the dentist usually sent them a reminder when they were due for a check-up. Those whose dentists did so were asked whether they made an appointment to see the dentist when the reminder was sent, at the end of their last course of

Table 17.11 When do informants who receive reminders make their dental appointments? (People with natural teeth)

Informant makes appointment:	Regular attender	Occasional only when trouble	Total
	%	%	%
At end of last course of treatment	18	8	15
When reminder sent	77	37	66
When feels it is time to go again	5	51	18
Other	—	3	1
Total	100	100	100
Base: People aged 16-64 with natural teeth whose dentist sends reminder			
	233	90	323

treatment, or when they felt it was time to go again. Among people with some natural teeth who had been to their dentist more than once, 34% said the dentist sent them a reminder. Table 17.11 shows that two thirds of these people did in fact make their appointment when they received the reminder. As one would expect, regular dental attenders were far more likely than those who went to the dentist infrequently to make an appointment when they received a reminder.

People whose dentist did not send reminders, or who had only been to their present dentist once were asked whether they made their dental appointments at the end of the last course of treatment, or when they felt it was time to go again. Among people with natural teeth only 26% said they made their next appointment at the end of their last course of treatment. This percentage rose to 49% of people who described themselves as regular attenders.

17.8 Emergency dental treatment

We included as emergency dental treatment any treatment which informants had attempted to get done outside normal surgery hours. In some areas of the country, special clinics are being set up to deal with dental emergencies; alternatively patients may seek help from their own dentists or at dental casualty departments in hospitals.

Only a very small proportion of the sample had tried to

Table 17.10 Future intentions by type of attender

Whether or not informant intends to go back to present dentist:	Those with natural teeth		Edentulous	
	Regular attender	Occasional/only when trouble		Total
	%	%	%	%
Yes, intends to go back	95	78	81	87
No, intends to change because:				
Location of dental practice is inconvenient	2	9	2	5
Dentist gave unsatisfactory treatment	1	4	5	3
Other reasons	2	6	6	4
Does not know	—	3	6	2
Total	100	100	100	100
Base: Informants aged 16-64 who had been to dentist in last 5 years				
	666	572	140	1382

Table 17.12 Proportions having had emergency treatment in last 5 years

	Those with natural teeth		Edentulous	Total
	Regular attender	Occasional/only when trouble	%	
Informant: had tried to have emergency treatment in last 5 years	10	5	1	6
had not tried	90	95	99	94
Total	100	100	100	100
Base: All informants	668	771	328	1769

obtain emergency dental treatment in the last five years. Somewhat surprisingly, regular attenders were found to be slightly more likely than the rest to have done so (Table 17.12).

Nearly half the small percentage (6%) who had sought emergency treatment in the last five years saw a dentist the same day and only around 13% were dissatisfied about the time they had to wait to see the dentist.

The main reasons given for seeking emergency treatment were for toothache, a broken tooth or damaged fillings (69 people); for an abscess (25 people); for other treatment, for example, ulcers or bleeding following extractions (15 people).

In all, 106 people had tried to see a dentist outside normal surgery hours, of whom about two fifths had tried to do so on the same day as the trouble started. It is possible that the other three fifths who waited till the following day or later to seek treatment hoped to be able to wait until normal surgery hours, but were unable to do so.

The outcome of the attempts to see a dentist out of hours is given below (Table 17.13).

Table 17.13 Outcome of attempts to see a dentist out of hours

	%
Informant saw own dentist	24
—treated same day	40
—next day or later	13
Informant saw other dentist	7
—treated same day	10
—next day or later	3
Saw dentist at hospital	4
—treated same day	100
—next day or later	106
Informant did not get treatment done	
Total	
Base: Informants aged 16–64 who had tried to get emergency treatment in the last 5 years	

Almost two thirds of people who tried to see a dentist out of hours saw their own dentist but only 24% managed to see him the same day. Overall 47% managed to see a dentist on the day they tried to see one. Four people said they did not get the treatment done at all.

Only 14 people (13%) expressed dissatisfaction about the time they had to wait to see the dentist, of whom seven had, in fact, waited two to three days before they sought treatment.

17.9 Summary

Among those who had been to the dentist within the past five years 12% had had some private treatment. Among people with natural teeth the percentage increased with age. No differences were found between people with different patterns of dental attendance or between social classes.

A higher proportion of people living in the South East than in other regions or countries had had private treatment.

Those who had had private treatment were almost equally divided between those who had had it from choice and those who would have preferred NHS treatment. The most common reason for having private treatment given by those who would have preferred NHS was that the required treatment was not available under the NHS. Crowning of teeth was the most frequently mentioned private treatment.

Thirty-eight per cent of those who had been during the past five years had travelled less than a mile to the dentist. Regional and country differences do not correspond to patterns of dental behaviour and health. Rural and non-rural differences are more marked: 22% of the former compared with 43% of the latter travelled less than a mile.

Perhaps surprisingly regular attenders were more likely than others to travel longer distances.

Fifty-three per cent of the sample had been attending the same dentist for five years or more, but the percentage fell from 60% among regular attenders to 45% among attenders 'only in trouble' and to 44% among the edentulous. Over four fifths of the sample intended to go back to the same dentist, a much higher proportion being found among regular attenders (95%).

18 Summary and conclusions

The main purposes of the present survey were to find out how accessible people in the United Kingdom found the primary health care services to be, whether accessibility was affected by the way the services were organised and to identify groups in the population with particular difficulties of access.

The principle finding of the survey is that in general for most people the primary health care services are easily accessible. Thus, for example, over 90% of informants found the journey to their doctor's surgery easy and half had to travel less than a mile to reach it, while 70% lived within a mile of the nearest pharmacy, and again, over 90% found the journey there to be easy. To reach a dentist, chiropodist or have a sight test most people had or chose to travel further, only around a third making a journey of less than one mile. Direct evidence of difficulties if any, were, nevertheless, confined to a small minority.

In the case of general practitioners a variety of other potential obstacles to access were considered; appointment systems, receptionists, people's views of their doctor's approachability and their impressions of the surgeries as well as the ease of getting home visits, of changing doctors and how they felt about being seen by a nurse or health visitor instead of by the doctor at his surgery. Evidence of difficulties or dissatisfaction was again limited to a small minority in every case.

For dentists, a possible additional source of difficulty foreseen was the problem of obtaining NHS treatment; 11% of people in the age range 16-64 had had private treatment during the preceding five years and under half of this group said they would have preferred NHS treatment.

A topic of particular interest in the case of general practitioners was whether recent developments in the organisation of practices, notably the growth in group practices and health centres as well as more efficient administrative arrangements such as the use of appointment systems and receptionists had reduced accessibility. At the time of the survey (1977), well under half the adults in the UK were using practices of four or more doctors, about 20% were using practices in health centres, most (64%) used practices operating appointment systems and nearly everyone used practices which had receptionists.

Group practices and health centres involve some clustering of doctors and all the arrangements mentioned might be expected to modify the personal

relationship between doctor and patient. In fact, although distances to surgeries varied with the number of doctors in the practice—surgeries of the largest practices being the furthest from peoples homes—the potential effects on proximity of clustering doctors was moderated by the operation of branch surgeries. Moreover, people were no more likely to find journeys to the surgeries of group practices difficult, regardless of the number of doctors involved, than journeys to surgeries of single-handed practices. Distances to doctors practising from health centres were no greater than distances to other doctors.

As already outlined, nearly two thirds of the informants used a practice with an appointment system and over 90% one with a receptionist; both arrangements being commonest in the larger practices and in health centres. Most of the people using practices with an appointment system were able to get an appointment for the same or following day, and thought getting one was easy. Similarly, most people had a favourable view of their doctor's receptionist and few saw her as a barrier to access to the doctor. In addition there was no indication that people using larger practices or health centres, compared with others, found their doctors any less approachable.

It seems therefore that the newer forms of practice organisation were generally no hindrance to accessibility. This confirms the findings of Cartwright and Anderson¹ who conclude from a comparison of evidence collected in 1963 and 1977, respectively, that quite major changes in the organisation of the general practitioner service had been accompanied by tiny changes in the relationship between doctors and patients and only a small decrease in physical accessibility.

The main reason for the lack of notable change in accessibility appears to be that both the service and users have adapted to the organisational developments. In the first case, as remarked earlier, group practices are more likely than single-handed practices to operate branch surgeries thus mitigating the effects of clustering. As far as the patients are concerned, Cartwright and Anderson note that the proportion using private transport to reach their doctor had almost doubled between 1963 and 1977. The present survey showed that use of a car to get to the surgery increased with its distance from home and that whereas most people who had to travel less than a mile walked, most of those who had to go at least two miles went by car. People's ability to adapt to changing circumstances, however, depends, in general terms very much on their

demographic and socio-economic characteristics, and we now turn to consider which groups experienced difficulties in accessibility.

In the first place it is useful to recall that the proportion reporting difficulties varied from about 5% to around 10% of all informants, depending on the service and aspect concerned. These are small proportions of the total adult population but represent upwards of 2,000,000 people—by no means negligible numbers.

As might be expected, the kind of area in which people lived affected physical accessibility, and on the whole country dwellers were more likely than others to experience difficulty. The difference in the case of GPs, however, was exceedingly small, but considerably larger for pharmacists which 15% of those in rural areas found difficult to reach, compared with only 4% in other areas. However, about 20% of the informants living in rural areas said their doctor usually supplied them with prescribed medicines, although the proportion varied between regions and counties.

Age, sex and social class, however, had a much greater effect on physical access. In the case of age this is partly because elderly people are the most likely to have difficulty in getting about generally, but a compounding factor is their low level of car ownership. In general it is the elderly, the families of semi- and unskilled workers and women who are least likely to have the use of a car. At the same time travel by public transport is the most likely to present people with difficulties in reaching services. Consequently problems were most common amongst the elderly and especially so if they were women and were in the manual group.

On the other hand it was elderly people who were most likely to hold favourable views of their doctor's approachability and of his receptionist, and people in the manual group were no less prone than others to have such favourable views.

It was also elderly people who more commonly than other age groups found that getting their doctor to make a home visit was easy. In this matter it was in fact people with children under five who were as likely as the elderly to ask for a home visit but particularly liable to say that getting their doctor to make one was difficult; although only about 20% of the group reported difficulty. The difference between the elderly and those with young children, however, assumes greater significance in view of the evidence of the General Household Survey of 1977 that about 40% of people aged 65 or more who had consulted their general practitioner in a two-week reference period had done so at home, compared with little over 15% of children under five who had been seen by a doctor². The high incidence of domiciliary consultations for elderly people also explains why the difficulty many of them experienced in getting to their doctor's surgery evidently made no impact on how often they consulted.

People who have some difficulty in consulting their doctors might turn elsewhere for advice and treatment for health problems. The survey evidence suggests, however, that whilst obstacles to access were sometimes involved, people's perceptions of their illness also affect whether they consult their doctors: those who consider consulting and then decide not to do so have usually concluded either that their complaint is too trivial to merit consultation, or else that it is not susceptible to treatment by their doctor, often because it is long-standing and sometimes because it is psychiatric.

The only alternatives to consulting general practitioners covered by the survey were; seeking advice from pharmacists and using hospital accident and emergency departments. Most of the 15% who had asked pharmacists for advice in the preceding year had done so for what appeared to be minor conditions, like colds and stomach upsets, whilst most of the 15% who had used an accident and emergency department in the same period (for themselves or their children) had evidently, indeed, experienced an accident or emergency.

There are, of course, other alternative sources of treatment or advice for health problems, like osteopaths, acupuncturists and other practitioners of non-conventional medicine, as well as self-medication. None of these was considered by the survey and it is therefore not possible to say to what extent such sources were used because they appeared to be more accessible in some way than general practitioners, rather than for other reasons. This is a subject which goes beyond the problem of accessibility and which is worth separate investigation as part of the wider question of the way in which pressure on limited health service resources is influenced by people's perceptions of their health and their decisions and actions—including preventive actions, like regular exercise—before they attempt or even contemplate contacting their doctors.

One of the costs of covering this full range of primary health care services is that not all can be examined in detail, and we have less information about the various aspects of accessibility for services other than general practitioners. It seems reasonable to assume, however, that some of the factors which affect access to general practitioners, like lack of a car, will also affect access to other services and be more prevalent obstacles in some groups than in others, although other circumstances may also be involved. Whatever the reasons, there was evidence that people in the manual group, and especially those in Social Classes IV and V, were less likely than others to make use of ophthalmic, dental and chiropody services, whilst the elderly were comparatively infrequent users of the first two.

Thus, a rather smaller proportion of people in Social Classes IV and V than others had ever had a sight test. However, since the survey findings suggest that people do go for sight tests when they are having trouble with their eye-sight and show that non-lens wearers in Social Classes IV and V were the least likely to feel a need to

have their sight tested, the class difference is probably not of practical consequence. The fact that a comparatively high proportion of lens wearers aged 75 or more had not had a sight test for at least two years might be similarly interpreted. However, the General Household Survey of 1977 found that people in this age group were particularly likely to wear glasses and have difficulty with their eyesight³. In this context, and given that many of them suffered from restricted mobility, it is of interest that so few of the elderly and so few of those whose mobility was restricted (around 15%) knew of the availability of domiciliary sight tests.

The evidence that regular visits to the dentist are much less common amongst the manual than non-manual groups is clearly a matter for concern in view of the relationships between regular attendance and dental health shown by the 1978 Adult Dental Health Survey, and between total toothloss and social class. The comparatively infrequent reports of regular visits to their dentist by elderly people is also worth noting, although this may in part be due to generational changes in attitudes towards dental health rather than to age differences.

Elderly people are the most likely to use chiropody services, but those in the manual groups, particularly in Social Classes IV and V, did so less than others; a difference entirely due to their lesser use of private as opposed to NHS treatment. It is possible that this indicates some unmet need for chiropody services, but only an enquiry which devoted more attention to this particular service and to foot health could provide a conclusive answer. In this connection it is worth remarking on the evidence that older women were much more likely to have had chiropody treatment than older men. Is this because elderly women are more liable than elderly men to suffer from foot problems? and if so is it related to the different kinds of shoes worn by men and women earlier in their lives?

In general, use of ophthalmic, dental and chiropody services appear to be more vulnerable to extraneous influences than use of general practitioners. The survey evidence was that none of the aspects of accessibility considered made more than a minor impact on use of general practitioners. Moreover, how often people said

they consulted their doctors varied with age, sex and social class in a way consistent with what is known about the distribution of health problems in the population⁴. In the case of the other services, however, we have seen that there are indications—and firm evidence for dental services—that some groups make less use of them than is wise. Perhaps people attach less importance to good eyesight, dental health and comfortable feet than to other aspects of their health and are therefore more easily deterred by difficulties of access. Moreover, these services tend to be situated further than doctors' surgeries from people's houses. However, such health problems in common with others accumulate with age and help to restrict activity*. It is therefore unfortunate if some which could be prevented or treated by existing services are neglected through under use of those services by some groups.

To sum up: for most people the primary health care services are easily accessible, whatever aspect of accessibility is considered. This is particularly true of general practitioner services and the evidence is that recent developments in the way they are organised have had remarkably little effect on how easy they are to use. Even the people who experience some difficulties in reaching theirs—notably the elderly—still seem on the whole to use them as much as they feel they need to do, because people and the service have adapted to changing circumstances. There was little direct evidence that other services are any more difficult to use, although people have to travel further to reach ophthalmic, dental and chiropody services. The patterns of use in these cases, however, in conjunction with the evidence of other surveys, suggests that some groups of the population make less use of them than good health requires.

References

- ¹ Ann Cartwright and Robert Anderson. *General Practice revisited*. Tavistock, 1981.
- ² OPCS. *General Household Survey 1977*. HMSO, 1979. p 99.
- ³ *Ibid.* p 96.
- ⁴ *Ibid.* p 80 *et seq.*

* The Royal Commission on the National Health Service, for example, after quoting a view of the very serious consequences for the elderly of untreated painful feet suggest that 'providing chiropody may well be an alternative to providing other, more costly community services' (*Report of the Royal Commission on the National Health Service*, HMSO, 1979, p 98).

Appendix A—Technical sampling report by Robert Butcher

A.1 Target population

The aim of this enquiry was to provide information about the use and accessibility of primary health care services. The sample to be selected needed to be nationally representative of all individuals aged 16 or over living in the United Kingdom in June 1977.

People not in private households, ie those in hospitals, homes for the old and disabled, educational establishments and other institutions, were excluded from the survey, because it is not possible to obtain a representative sample of them without a large and costly special exercise. This is especially so when using the electoral register as a sampling frame since many people in institutions do not appear on the register. However, people living in hotels and boarding houses were included if they were permanently resident within a private household at the address. From census figures it is estimated that about 3% of people have been excluded from the target population because they live in institutions.

A further 0.2% were omitted because they lived on Scottish islands or in the Isles of Scilly. These are frequently omitted from surveys because of the inordinate effort and expense required to cover them.

A.2 Sample size

One problem in designing this sample was to ensure that the important subgroups described below contained sufficient numbers to be analysed separately. There are three controls that were used; one is the total sample size, ie the larger the whole sample then the larger the number in each subgroup; secondly differential sampling fractions were used to obtain proportionally more of one subgroup than another, and thirdly stratification was used to make sure that within subgroups the sample size achieved was as close to the expected size as possible, so that chance fluctuations did not leave an important subgroup with too few cases.

One group for which extensive analysis was anticipated was the elderly and it was suggested that people aged 65 or over should be over-sampled by a factor of two to provide sufficient numbers in this group without having to interview more under 65s than was necessary. In fact at the time it was suggested that the sample should be designed to include sufficient people aged 75 and over for separate analysis of this group. It was felt that this would make the survey too expensive given that its main aim was to investigate the experiences of the general population. The solution eventually adopted was to make the sample large enough to provide sufficient

people aged 65 and over. This of course yielded more than enough people under 65 and therefore had the incidental advantage of making it possible to cover a long list of topics by confining some of the questions to only part of the sample. Thus, as described in detail in Chapter 1, everyone in the sample was asked to answer a basic core of questions: half the under 65s and all the older people were asked some of the remaining questions; and the rest of the questions which were likely to be less relevant to the older group, were addressed only to the other half of the under 65s.

The other groups that were considered important were those in designated areas—where the ratio of patients to doctors is relatively high (see Chapter 3)—because the DHSS thought that this ratio was an important factor in the quality of primary health care service; people in rural areas, who may have greater difficulty in reaching various services, and people who are registered at health centres, which have been of policy interest to the DHSS for some time. It was predicted that such extensive analysis would not be required of other subgroups but in determining the total sample size the size of these subsamples were taken into account. In particular we considered which of the smaller subgroups in the sample were likely to require separate analysis and what sample size would be needed to satisfy this. Two such subgroups were:

- i) people who had consulted a GP in a health centre in a designated area within the last year; and
- ii) people aged 65 or over who had consulted a GP at a health centre within the last year.

With these constraints it was calculated that a sample size in GB of about 5000 would be sufficient.

Finally, the Scottish Home and Health Department requested a larger than proportional sample in Scotland so that Scottish results would be more reliable. A double size sample was therefore taken in Scotland.

Thus the set sample size issued was 5631 of which 130 were in Northern Ireland, 943 were in Scotland and 237 in Wales.

A.3 Sample design

As is usual for a national interview survey a stratified, multi-stage sample design was used. The aim was a representative sample of individuals aged 16 or over from throughout the UK.

A3.1 The multi-stage design

The clustering entailed by a multi-stage design can have a strong adverse effect on the precision of the survey when it is measuring variables that take similar values for people living in the same geographical area. In this survey there were a number of such variables. For example whether people use a health centre or not will depend on whether the areas selected for the sample happen to contain health centres. Because we had to measure such variables with reasonable precision the sample was spread more widely than we would otherwise have done. Nevertheless, the cost of travelling between addresses meant that the sample had to be clustered to some extent. We decided to select 150 local authority districts from Great Britain, and to cluster our sample within four wards selected from each of these districts. In order to obtain the double size sample from Scotland another 14 districts were selected from there, making 164 districts altogether selected from Great Britain. In Northern Ireland the sample was drawn from 27 wards spread throughout the country.

A3.2 Districts in Great Britain—stratification and selection

Before the districts and wards were selected they were stratified in order to ensure that the sample would be as representative as possible. There were a number of stratification factors that could have been used, but only a limited amount of stratification is possible with 164 Primary Sampling Units or Districts. It is generally thought better to use as many factors as possible, if necessary banded in a coarse way, rather than to keep the factors finely banded and be restricted in the number one can use. Three factors were used for this survey, as follows. First of all many analyses by region were anticipated and so region was used as one factor. Economic planning regions were used in preference to regions defined in other ways as at the time of designing

the sample it was felt that these were more appropriate than Regional Health Authorities for primary health care purposes. These were grouped to give five broad regions in Great Britain. The other factor used for stratifying districts was the percentage of patients living in designated areas. This variable was thought to be related to the accessibility of primary health care as described in section 2 on the sample size. Percent designation was banded so that 0%, which was the most common value stood alone, and then three bands of very approximately equal size were created. Within strata two ranking factors were used: i) the density of persons per hectare which was chosen as a proxy for an urban-rural classification and ii) the proportion of people in a district who were aged 65 or over. Density was banded in an attempt to indicate rural (0-2.4 electors per hectare), semi-rural (2.5-19.9) and urban areas (20 or more). Whilst percent aged 65 or over was used for ranking within density bands, Table A.1 shows the allocation of districts over the two stratification factors and by density band.

A3.3 Districts in Great Britain—selection

Having ranked the districts within each density band in ascending order of percentage over 65 within strata there are a number of possible methods for selecting districts with probability proportional to 1976 electorate size. The disadvantage with a systematic random sample is that most random starts produce a sample which is known to be non-typical, eg a high random start gives a higher than average proportion of old people. The method used here keeps the advantage of systematic selection, that small districts cannot be selected twice, whilst trying to avoid this disadvantage. Within strata an interval was calculated by dividing the total electorate by the number of districts to be selected. Then groups of districts were formed by taking the first district in the stratum and adding further districts until

Table A.1 Allocation of districts in Great Britain by the three stratification factors: region, percent designation and density

% Designated	Density	South		Midlands		North		Wales		Scotland		Total A
		E	A	E	A	E	A	E	A	E	A	
0	Low	11.2	12	8.4	9	3.9	4	2.2	2	8.0	8	35
	Med	14.1	14	3.7	4	7.7	8	3.8	3	9.1	10	39
	High	26.0	26	4.0	4	6.9	6	0.8	1	4.8	4	41
1-30	Low	0.6	—	0.5	1	0.4	—	0	—	3.6	—	11
	Med	0.7	1	0.5	—	4.5	5	0.5	1	0.6	4	11
	High	1.5	1	4.5	5	1.7	2	0	—	0	—	8
31-69	Low	1.0	1	0.6	—	0.2	1	0	—	0.2	—	2
	Med	1.6	2	1.6	2	6.5	6	0.4	—	0	—	10
	High	0.6	—	2.4	2	3.2	3	0	—	0	—	5
70-100	Low	0	—	0.7	—	0.3	—	0	—	0.3	—	—
	Med	0.8	1	1.7	3	4.3	5	0	—	1.7	2	11
	High	0.6	1	0.7	—	0.8	—	0	—	0	—	1
Total		58.6	59	29.3	30	40.3	40	7.7	7	28.1	28	164

Notes:

1. E = expected allocation according to 1976 electorate

A = actual allocation

High = 20 or more persons per hectare

Med = 2.5-19.9 persons per hectare

Low = 2.4 or less persons per hectare

South includes the South East and South West regions

Midlands includes the West Midlands, East Midlands and East Anglian regions

North includes the North West, the Yorkshire and Humberside and the Northern regions

2. The actual allocation was determined by randomly rounding up or down in proportion to the fractional part of the expected allocation

the joint electorate was as large as possible but less than the interval; then taking the next district and forming a group in the same way; and so on. Table A.2 shows how this was done for the North region in designation band 31%–69%. There were then two stages in selecting the districts. First a systematic random selection was made of the groups of districts by selecting a random number, n , between one and the interval and taking the group containing the n th elector, the group containing the elector numbered n plus the interval and so on adding the interval until the end of the stratum. The second stage was to select one district from within each sampled group. This was achieved by selecting a random number between one and the electorate size of the group and taking the district containing that number elector, as shown in Table A.2. In this way 164 district selections were made.

Table A.2 District selection in the North region, designated band 31%–69%

District	Density	% aged 65 or over	Electorate	Cumulated electorate and formation of groups	Cumulated electorate of groups	Groups selected	Random number in group	District selected
Selby	0.9	17	52,301	52,301				*
Langburgh	6.0	14	107,080	159,381	159,381	*	31,790	*
Stockton-on-Tees	8.4	14	120,608	120,608	343,806	*	55,213	*
Durham	4.3	15	63,817	184,425	546,700			*
Doncaster	4.8	15	202,894	202,894	770,910	*	—	*
Wigan	15.2	16	224,210	224,210	921,728	*	—	*
Rochdale	12.7	17	150,818	150,818	1,085,180	*	—	*
Oldham	15.9	17	163,452	163,452	1,248,630	*	—	*
Bury	17.6	17	128,860	128,860	1,476,638	*	—	*
Sheffield	15.6	18	420,326	420,326	1,634,366	*	—	*
Calderdale	5.4	20	142,308	142,308	1,776,674			*
Stockport	23.2	16	212,650	212,650	1,989,324	*	—	*
Tameside	21.4	17	163,620	163,620	2,152,944	*	—	*
North Tyneside	24.8	17	151,792	151,792	2,304,736	*	—	*
South Tyneside	27.8	17	128,525	128,525	2,433,261	*	—	*
Salford	28.9	17	192,715	192,715	2,625,976			

Total electorate = 2,625,976

No. of selections in stratum = 10

Interval = $\frac{2,625,976}{10} = 262,598$

Random start (between 1 and 262,598) = 57,216

Note that Sheffield has been divided into 2 groups as it is larger than the interval. In fact it has been selected twice.

A3.4 Wards in Great Britain—stratification and selection

Within each district four wards or groups of wards were selected with probability proportional to their 1976 electorate size. (In the few cases where the district had been selected two, three or four times, there were eight, 12 or 16 wards, or groups of wards, selected within the district.) Groups of contiguous wards were created where necessary so that no group or ward had less than 200 electors. These wards/groups were then ranked in descending order of density within up to four parts. In the first two parts were those wards that had a health centre in the vicinity. The rest were in the second two parts. Finally in parts one and three were listed wards which contained any fraction of a designated area. Then four (or the required number) of wards/groups were selected from this list using a systematic random sample.

A3.5 Electors in Great Britain—selection

An average of 8.5 electors were systematically selected from throughout each ward in the sample from the 1977 electoral register (which was compiled in October 1976). Because the wards and districts had been selected using 1976 electorate figures the number of electors selected within each ward varied slightly. This was in order to keep the same overall probability of selection of 1/7050 for each elector. So for example for ward number four in area number 143 the 1976 electorate was 2644 and the 1977 electorate was 2622. To determine the interval, 2644 (not 2622) was divided by 8.5 to give 311 which from the current electorate gave an expected number of 8.4 not 8.5. In fact eight were selected. In a few areas the differences were more significant. The final sample selected from the register in GB was 5501.

A3.6 Northern Ireland—stratification and selection

The Primary Sampling Units in this country were wards. The stratification factors were region and density—'designated area' is not a concept used in Northern Ireland. Three wards were systematically selected from each stratum with probability proportional to electorate, yielding 27 wards in all. Within each ward an average of 4.8 electors were selected systematically, but this average varied a lot from stratum to stratum because the strata were not of equal size. The final set sample was 130. The sampling in Northern Ireland, like the field work, was carried out for OPCS by the Statistics and Economics Unit, Department of Finance at Stormont, Belfast.

A4 Obtaining a sample of individuals

There are a number of possible methods for obtaining a sample of individuals. The method adopted in this

survey was to take a sample of electors from the electoral register and to use special procedures to overcome the two problems encountered: i) that a proportion of the electorate will have moved between the compilation of the register and the date of the interview, and ii) a number of people aged 16 and over do not appear on the register because they are ineligible to vote or because they did not return the registration form. The special procedures used in this case were those described by Marchant and Blyth in their paper¹ and outlined here.

The principle of the method is that at each address the interviewer, not only interviews the selected elector (if still living there) but also interviews a sample of any other eligible people there who do not appear on the electoral register at the address. As most adults are registered as electors, most addresses present only one person for interview. In some cases the selected elector has left the address, no one else has moved in and so there is no interview required. In other cases two interviews are required and in a few cases three or four. The advantage of this method is that we obtain a sample of all people who are at present living at an address that is on the register (and not just of those people who are electors). Also the sample is self-weighting, ie everyone has the same chance of selection. The people omitted with this sort of sample are those who live in addresses that are not on the register, whether this is because the addresses were unoccupied at the time of compilation of the register or have been built since, or because no one at the address is eligible to vote or else no one has registered him or herself as an elector. With our present knowledge we estimate that this excludes approximately 7-10% of the population. This is believed to be less than the loss from using other sampling methods.

A5 Analysis of response

The usual analysis of response is presented in the introduction to this report in Chapter 1. Two other ways of analysing response are presented here. Table A.3 gives a rough estimate of the coverage of the target population by the survey whilst Table A.4 gives the details of the results of the Marchant-Blyth sampling procedure.

A6 Validation of the sample

The achieved sample has been compared in the following tables with the available population figures. These are restricted to age by sex by country and sex by both standard region and Regional Health Authority.

Chi-squared tests have been carried out to indicate where differences may be due to influences other than sampling error, although it must be borne in mind that these tests are not appropriate with a clustered sample such as this.

In fact the only points worth noting arise from Table A.5 where it can be seen that the achieved sample in England contained fewer young men and women (16-

Table A.3 Showing respondents as a percentage of the target population

Target population*	100%
Population in addresses omitted from the electoral register because the addresses were	8%
—built and occupied since compilation of register†	(1%)
—already built but occupied only since compilation‡	(1-3%)
—occupied at compilation but more eligible to vote§	(2%)
—occupied at compilation but eligible people did not register**	(3%)
Population in addresses on the electoral register from which the sample was drawn	92%
Refusals	5½%
Non-contacts	5½%
Respondents	81%

* From section 1, the target population consists of all people in the UK in June/July 1977 who are aged 16 or over and who live in private households (ie not in institutions). The islands of Scotland are also excluded.

† From the Annual Abstract of Statistics 1977 assuming that occupation of newly completed properties occurs at the same rate as they are built.

‡ the recently completed Vacant Properties Survey estimates that about 3% of dwellings are vacant at any one time of which about ½ become occupied after three to four months.

§ This assumes that the proportion of people in private households who are not eligible to vote is about the same as the census 1971 figure for those people born in non-commonwealth countries.

** From the paper by Gray and Gee, Electoral registration for parliamentary elections published by the Government Social survey.

Table A.4 Showing the outcome at the address of each selected elector

Selected electors	5632	
Address empty or demolished	—160	
Institution	—13	
Addresses to be dealt with	5459	
Addresses at which sampling procedure was not carried out	—180	
No one contacted	126	
Person 1 moved or died—no other information	21	
Refusal to cooperate at all	30	
Selected elector interviewed but sampling procedure not carried out	3 (a)	
Addresses at which sampling procedure was carried out	5279	96%
No interview required	306	5.8
1 person selected for interview	4746	89.9
2 people selected for interview	215	4.1
3 people selected for interview	10	0.2
4 people selected for interview	2	—
	5279	100.0
Total eligible people selected from these 5279 addresses	5214	
Non contacts	158	
Refusal to be interviewed	268	
Interviews	4788 (b)	
Total interviews (a + b)	4791 (a + b)	

24) than expected and too many middle aged women (35-54); whereas in Scotland it appears there were too few young men (25-34) and too many older ones (65-74).

In the other two tables A.6 and A.7 the usual chi-squared test does show significant differences but if we

* The design effect, DEFF, of 25 is estimated using the formula $DEFF = 1 + (b-1)p$ where b is the average number of interviews per PSU and p is the intra-cluster correlation coefficient. In this case p is equal to 1 since either all the people in a PSU are in the particular region or else none of them are.

Table A.5 Comparison of the sample and mid-1977 population by country, age and sex. (Persons aged 16 and over)

Age and sex	England		Wales		Scotland		Northern Ireland		UK	
	Pop %	Sample %	Pop %	Sample %	Pop %	Sample %	Pop %	Sample %	Pop %	Sample %
16-24	M 7.3*	6.3	0.4	0.3	0.9	0.8	0.3	0.3	8.9	7.7
	F 7.0*	6.1	0.4	0.4	0.8	0.8	0.3	0.3	8.5	7.6
25-34	M 7.8	8.1	0.5	0.2	0.8*	0.6	0.2	0.2	9.3	9.1
	F 7.7	7.7	0.5	0.3	0.8	0.8	0.2	0.3	9.2	9.1
35-44	M 6.3	6.1	0.4	0.4	0.7	0.6	0.2	0.2	7.6	7.3
	F 6.1*	7.1	0.3	0.4	0.7	0.8	0.2	0.2	7.3	8.5
45-54	M 6.4	6.3	0.4	0.3	0.7	0.6	0.2	0.2	7.7	7.4
	F 6.5*	7.9	0.4	0.4	0.7	0.6	0.2	0.2	7.8	9.1
55-64	M 5.9	5.8	0.4	0.5	0.6	0.7	0.2	0.2	7.1	7.2
	F 6.5	6.7	0.4	0.4	0.7	0.8	0.2	0.2	7.8	8.1
65-74	M 4.3	4.7	0.3	0.2	0.4*	0.6	0.1	0.0	5.1	5.5
	F 5.7	5.8	0.3	0.2	0.6	0.7	0.2	0.2	6.8	6.9
75 and over	M 1.8	1.7	0.1	0.2	0.2	0.2	0.05	0.1	2.2	2.2
	F 3.9	3.4	0.2	0.2	0.4	0.3	0.1	0.1	4.6	4.0
All ages	M 39.9	39.0	2.4	2.3	4.3	4.1	1.3	1.2	47.8	46.5
	F 43.4	44.7	2.6	2.3	4.8	4.9	1.4	1.6	52.2	53.5
Total	83.2	83.7	5.0	4.6	9.0	9.0	2.6	2.8	100	100

% Base (Population in thousands, sample re-weighted for Scotland)

42470 4337

* Indicates those differences that are statistically significant at the 5% level according to the chi-squared test.

Table A.6 Comparison of the sample and mid-1977 population by standard region and sex. (Persons aged 16 and over)

Region and country	Males		Females		Persons	
	Pop %	Sample %	Pop %	Sample %	Pop %	Sample %
Northern	2.7	2.5	2.9	3.6	5.6	6.1
Yorkshire and Humberside	4.2	3.5	4.5	4.0	8.7	7.5
North West	5.5	6.1	6.1	6.9	11.6	13.0
East Midlands	3.2	2.7	3.4	3.1	6.6	5.8
West Midlands	4.4	6.0	4.7	6.2	9.1	12.2
East Anglia	1.6	1.0	1.7	0.9	3.3	1.9
South East (excl. GLC)	8.5	5.7	9.2	6.8	17.7	12.5
GLC	6.0	7.9	6.8	8.9	12.8	16.8
South West	3.7	3.5	4.1	4.2	7.8	7.7
England	39.8	38.9	43.4	44.6	83.2	83.5
Wales	2.4	2.3	2.6	2.3	5.0	4.6
Scotland	4.3	4.1	4.8	4.9	9.1	9.0
Northern Ireland	1.3	1.2	1.4	1.6	2.7	2.8
Total UK	47.8	46.5	52.2	53.4	100	100

% Base (Population in thousands, sample re-weighted for Scotland)

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Table A.7 Comparison of the sample and mid-1977 population by Regional Health Authority and sex. (Persons aged 16 and over)

Regional Health Authority	Males		Females		Persons	
	Pop %	Sample %	Pop %	Sample %	Pop %	Sample %
Northern	2.7	2.5	2.9	3.6	5.6	6.1
Yorkshire	3.1	2.5	3.3	2.8	6.4	5.3
Trent	3.9	3.4	4.2	4.0	8.1	7.4
East Anglia	1.6	1.1	1.7	1.0	3.3	2.1
NW Thames	3.0	2.9	3.3	3.3	6.3	6.2
NE Thames	3.2	2.1	3.5	2.1	6.7	4.2
SE Thames	3.0	3.9	3.4	4.1	6.4	8.0
SW Thames	2.5	2.6	2.8	3.7	5.3	6.3
South West	2.8	2.6	3.0	3.3	5.8	5.9
Oxford	2.0	1.4	2.0	1.6	4.0	3.0
Wessex	2.3	2.0	2.4	2.2	4.7	4.2
West Midlands	4.4	5.9	4.7	6.1	9.1	12.0
Mersey	2.1	2.3	2.3	3.0	4.4	5.3
North West	3.4	3.7	3.8	3.9	7.2	7.6
England	40.0	38.9	43.3	44.7	83.3	83.6
Wales	2.4	2.3	2.6	2.4	5.0	4.7
Scotland	4.3	4.1	4.8	4.9	9.1	9.0
Northern Ireland	1.3	1.2	1.3	1.6	2.6	2.8
Total UK	48.0	46.5	52.0	53.6	100	100

% Base (Population in thousands, sample re-weighted for Scotland)

42470 4337

divide it by the design effect*, which is approximately equal to the average number of interviews achieved per PSU, that is, 25 for the variable 'region', then none of the differences are statistically significant. The problem here is that there was no control over individual region

within broad region since the stratification factor was broad region.

Reference

- W A Blyth and L J Marchant. A self-weighting random sampling technique. *Journal of the Market Research Society*, 15, 1973. p 157.

Appendix B Sampling errors*

Introduction

All the figures presented and discussed in the report are of course derived from a sample of the population and are therefore estimates of the population values to which they relate. Some possible sources of bias (which affect the validity of estimates) are discussed in Appendix A.6 on sampling (validation of the sample, page 134). This Appendix deals with limitations on the *precision* of estimates; that is, sampling errors.

For a simple random sample (srs) the formula for calculating the estimated standard error of a sample percentage (p) is, ignoring the finite population correction,

$$s.e.(p_{srs}) = \sqrt{pq/n} \quad \dots \dots \dots (1)$$

where $q = (100-p)$ and n is the base sample size for the percentage. Since the calculations in this case depend only on the values of p and n the standard errors corresponding to a range of values of p and n can be simply presented in a two way table as shown in Table B.1. This would enable the reader to attach sampling errors to any percentage shown in the report.

In fact, the sample for this, as for most surveys, is not a simple random one, but is instead multi-stage and stratified. This means that sampling errors are generally larger than they would be for a simple random sample of the same size. They depend not only on the percentage and base sample size concerned, but also on how the particular characteristic in question is spread throughout the Primary Sampling Units (PSUs), and also—where applicable—on the way the sub-group of interest is spread through the Primary Sampling Units.

That is to say, a characteristic which tends to be clustered in some sampled areas will have greater sampling errors attached to it than one which is evenly spread over all areas.

The standard errors which would apply to a simple random sample and those computed for the complex sample are related by the 'design effects'; the estimated design effect for a sample percentage (p) being defined as:

$$deff(p) = \frac{\text{estimated variance of } p \text{ with the complex design}}{\text{estimated variance of } p \text{ with a srs of the same size}}$$

The variance is the square of the sampling error and in later pages it will be $\sqrt{deff(p)}$ which is shown, since it is $\sqrt{deff(p)}$ by which the srs standard error must be multiplied to give the standard error for the complex design, ie

$$s.e.(p) = \sqrt{deff(p)} \times s.e.(p_{srs}) \dots \dots \dots (2)$$

Because complex standard errors depend on the way characteristics are spread over the Primary Sampling Units a unique standard error applies to every percentage shown in the report. To calculate every one would involve an excessive amount of computation, and presenting a standard error with every percentage would produce dense and cumbersome tables. Such a form of presentation, moreover, would omit standard errors of the differences between percentages which are often of greater interest than those of individual percentages.

Since it is impracticable to provide all standard errors, the object of this appendix is to give the reader some guide to the size of the sampling errors which attach to the results.

After describing the method (which is mainly of technical interest) we show:

1. The standard errors for various values of p and n which would apply if the survey were based on a simple random sample (Table B.1).
2. The \sqrt{deff} for a number of items of key interest, which indicates the extent to which each is affected by the way the characteristic concerned is distributed over the PSUs, and which is the figure by which the $s.e.(p_{srs})$ must be multiplied to give the complex standard error (Table B.2).
3. The actual estimated complex standard errors and \sqrt{deff} for a number of key items (Table B.3).
4. The estimated complex standard errors of some differences between key percentages (Table B.4).

The method of calculating sampling errors

The appropriate method for calculating sampling errors for this survey is basically that described by L. Kish and I. Hess in their paper entitled *On variances of ratios and their differences in multi-stage samples*, *JASA*, 54, 1959, pp 416-446.

The basic formula

The formula used here is the one for systematic selections but with modification for stratification. For

* This appendix draws heavily on Chapter 7 of the *General Household Survey 1972* by Graham Kalton and Susan Lewis (HMSO, 1973).

Fig. B.1 Showing the 32 bands used for calculating sampling errors

Region or country	% Designated and density											
	0%			1%—30%			31%—69%			70%—100%		
	Low	Med	High	Low	Med	High	Low	Med	High	Low	Med	High
South East	1	6	9	12	—	—	—	—	—	—	—	—
South West	2	—	—	—	—	—	—	—	—	—	—	—
Midlands	3	7	10	13	—	14	13	—	14	15	—	—
Wales	4	—	—	—	—	—	—	—	—	—	—	—
North	5	8	11	16	—	17	18	—	17	19	—	17
Scotland	20	21	22	23	—	—	—	—	—	—	—	—
N. Ireland,												
Belfast*	24	25	26									
N. Ireland, East*	27	28	29									
N. Ireland, West*	30	31	32									

* The classification 'Designated/not Designated' does not apply to N. Ireland.

the purpose of calculating sampling errors the strata have been collapsed to give 32 bands as shown in Figure B.1.

The number shown in each cell in Figure B.1 is the band number assigned to all PSUs falling within that cell (or cells where indicated).

Let y_{bp} be the weighted total for PSU p in band b of the variable under consideration.

Let x_{bp} be the weighted size of the (achieved) sample under consideration in PSU p and band b .

$$\text{Let } y = \sum_{b=1}^{32} \sum_{p=1}^{a_b} y_{bp} \text{ and } x = \sum_{b=1}^{32} \sum_{p=1}^{a_b} x_{bp} \dots (3)$$

where a_b = the number of PSUs in band b .

Then $r = y/x$ is the estimate for which we wish to calculate the variance. This estimate is the ratio of two variables y and x . The sample size x is a variable because of non-response (and also because it often refers to a subgroup of the whole sample). Any estimate from the survey is a ratio estimate. For example, the proportion of all people aged 16 or over who have consulted a private doctor in the past year, is the ratio of the number of people picked up by the survey who have consulted a private doctor, to the total number of responders. Both of these are variables.

The variance of r is estimated by:

$$\text{var } r = \frac{1}{x^2} [\text{var } y + r^2 \text{ var } x - 2r \text{ cov}(xy)] \dots (4)$$

$$\text{where var } x = \sum_{b=1}^{32} \frac{a_b}{2(a_b-1)} \sum_{p=1}^{a_b-1} (x_{bp} - x_{bp+1})^2 \dots (5)$$

var y is defined similarly and

$$\text{cov}(xy) = \sum_{b=1}^{32} \frac{a_b}{2(a_b-1)} \sum_{p=1}^{a_b-1} (x_{bp} - x_{bp+1})(y_{bp} - y_{bp+1}) \dots (6)$$

The difference of two ratios

The variance of the difference of two ratios is calculated using the formula

$$\text{var}(r_1 - r_2) = \text{var } r_1 + \text{var } r_2 - 2 \text{ cov}(r_1, r_2)$$

where $\text{var } r_1$ and $\text{var } r_2$ are calculated as in (4) and

$$\text{cov}(r_1, r_2) = \frac{1}{x_1 - x_2} [\text{cov}(y_1, y_2) + r_1 r_2 \text{ cov}(x_1, x_2) - r_1 \text{ cov}(x_1, y_2) - r_2 \text{ cov}(x_2, y_1)]$$

where the COVs within the square brackets can be calculated using formula (6).

Checks

A little caution is necessary when dealing with ratio estimates because they are, in general, biased, that is if the value of the ratio is measured over all samples that could have been drawn using this sampling scheme then the average is not equal to the population value. Although the bias is usually small it needs to be checked. Also the formula for the variance of a ratio is only an approximation.

The bias is small and the variance approximation is close when there is little variation in the achieved sample size, x . A simple guide is to calculate the coefficient of variation of x , $\text{cv}(x)$ and to check that this is less than 0.1.

$$\text{CV}(x) = \frac{\sqrt{\text{var}(x)}}{x}$$

where x is calculated at (3) and $\text{var } x$ at (5).

In the case of the difference between two ratios, the greater of $\text{cv}(x_1)$ and $\text{cv}(x_2)$ should be less than 0.1.

Table B.1 The standard error for a percentage p calculated using the srs formula (1) for various values of p and n

$p(\%)$ n	5 95	10 90	15 85	20 80	25 75	30 70	35 65	40 60	45 55	50
	$\%_0$	$\%_0$	$\%_0$	$\%_0$	$\%_0$	$\%_0$	$\%_0$	$\%_0$	$\%_0$	$\%_0$
25	4.36	6.00	7.14	8.00	8.66	9.17	9.54	9.80	9.95	10.00
50	3.08	4.24	5.05	5.66	6.12	6.48	6.75	6.93	7.04	7.07
75	2.52	3.46	4.12	4.62	5.00	5.29	5.51	5.66	5.74	5.77
100	2.17	3.00	3.57	4.00	4.33	4.58	4.77	4.90	4.97	5.00
200	1.54	2.12	2.52	2.83	3.06	3.24	3.37	3.46	3.52	3.54
300	1.25	1.73	2.06	2.31	2.50	2.65	2.75	2.83	2.87	2.89
400	1.09	1.50	1.79	2.00	2.17	2.29	2.38	2.45	2.49	2.50
500	0.97	1.34	1.60	1.79	1.94	2.05	2.13	2.19	2.22	2.24
750	0.80	1.09	1.30	1.46	1.58	1.67	1.74	1.79	1.82	1.83
1000	0.69	0.95	1.13	1.26	1.34	1.45	1.51	1.55	1.57	1.58
1500	0.56	0.77	0.92	1.03	1.12	1.18	1.23	1.26	1.28	1.29
2000	0.49	0.67	0.80	0.89	0.97	1.02	1.07	1.10	1.11	1.12
3000	0.40	0.55	0.65	0.73	0.79	0.84	0.87	0.89	0.91	0.91
4000	0.34	0.47	0.56	0.63	0.68	0.72	0.75	0.77	0.79	0.79

Table B.2 Comparison of $\sqrt{\text{deff}}$ for some key characteristics for the United Kingdom, England, Wales, Scotland and Northern Ireland

Characteristics	United Kingdom	England	Wales	Scotland	Northern Ireland
	$\sqrt{\text{deff}}$	$\sqrt{\text{deff}}$	$\sqrt{\text{deff}}$	$\sqrt{\text{deff}}$	$\sqrt{\text{deff}}$
Size of practice attended:					
single-handed	1.86	2.02	2.98	1.50	1.34
4 or more doctors	2.13	2.27	1.95	2.24	1.23
6 or more doctors	2.24	2.33	2.91	2.50	0.79
Average list size:					
more than 2,500	1.81	1.99	1.35	1.64	1.36
more than 3,000	1.85	2.01	2.77	0.78	1.06
Practice attended is in:					
Health Centre	2.02	2.21	2.86	2.17	0.93
Practice attended is in:					
MPC designated area	1.90	1.50	—	4.24	—
Distance of surgery from home:					
less than 1 mile	—	1.47	1.43	1.70	1.46
5 or more miles	—	1.39	1.63	1.68	1.10
Rural areas					
less than 1 mile	—	2.04	1.30	1.26	0.87
5 or more miles	—	1.71	1.44	1.53	1.21
Non-rural areas					
less than 1 mile	—	1.35	1.07	1.74	1.70
5 or more miles	—	1.00	1.38	1.64	1.10

Table B.3 Standard errors for some key characteristics

Characteristic	Per cent	Sample size	Standard error	$\sqrt{\text{defl}}$
Attends single-handed practice				
UK	17	4289	1.07	1.86
England	17	3576	1.27	2.02
Wales	17	203	7.86	2.98
Scotland	14	779	1.87	1.50
N. Ireland	20	119	4.90	1.34
Attends practice of 6 or more doctors				
UK	11	4289	1.07	2.24
England	11	3576	1.22	2.33
Wales	9	203	5.84	2.91
Scotland	13	779	3.01	2.50
N. Ireland	1	119	0.72	0.79
Attends practice with average list size of more than 3000				
UK	17	4289	1.06	1.85
England	19	3576	1.32	2.01
Wales	5	203	4.23	2.77
Scotland	5	779	1.56	0.78
N. Ireland	13	119	3.28	1.06
Attends practice in a Health Centre				
UK	19	4289	1.21	2.02
England	17	3576	1.39	2.21
Wales	21	203	6.01	2.86
Scotland	22	779	3.22	2.17
N. Ireland	54	119	4.23	0.93
Surgery is less than one mile from home				
UK	49	4289	1.10	1.89
England	50	3576	1.23	1.47
Wales	49	203	5.03	1.43
Scotland	45	779	3.03	1.70
N. Ireland	26	119	5.87	1.46
Surgery is less than 1 mile from home				
Rural:				
England	34	776	3.48	2.04
Wales	32	60	7.85	1.30
Scotland	47	224	4.20	1.26
N. Ireland	3	60	1.92	0.87
Non-rural:				
England	55	2800	1.27	1.35
Wales	56	143	4.45	1.07
Scotland	45	555	3.67	1.74
N. Ireland	48	60	10.95	1.70
Attends practice with branch surgery				
UK	35	4289	1.62	2.22
Has not consulted doctor in last year				
UK	28	4289	0.67	0.98
Has consulted more than 10 times in last year				
UK	9	4289	0.40	0.92

Note: The sample size shown for the UK is the weighted number. Those shown for Scotland, and used to calculate the s.e.s, are unweighted.

Table B.4 Standard errors for some key differences between two sample percentages
(i) Differences between countries of the United Kingdom

Country	Characteristic	%	n	Standard error	Significance
England	Attends practice of	11	3576		
v	6 or more	9	203	5.97	ns
a) Wales	doctors	13	779	3.24	ns
b) Scotland		1	119	1.42	***
c) N. Ireland		9	203		
Wales		13	779	6.57	ns
v		1	119	5.89	ns
a) Scotland		13	779		
b) N. Ireland		1	119		
Scotland		13	779		
v		1	119	3.09	***
N. Ireland		50	3576		
England	Surgery is less	49	203	5.17	ns
v	than 1 mile	45	779	3.28	ns
a) Wales	from home	26	119	6.00	***
b) Scotland		49	203		
c) N. Ireland		45	779	5.87	ns
Wales		26	119	7.73	**
v		45	779		
a) Scotland		26	119		
b) N. Ireland		45	779		
Scotland		26	119	6.61	**
v					
N. Ireland					

(ii) Differences between other sub-groups

Sub-group	Characteristic	%	n	Standard error	Significance
Total—Single-handed practice v	Has branch surgery	15	724		
a) 2-3 doctors		37	1853	3.07	***
b) 4-5 doctors		44	1230	3.72	***
c) 6 or more doctors		37	466	5.91	***
Rural—Single-handed practice v		36	110		
a) 2-3 doctors		49	442	8.50	ns
b) 4-5 doctors		54	318	9.55	ns
c) 6 or more doctors		52	135	12.46	ns
Non-Rural—Single-handed practice v		11	613		
a) 2-3 doctors		34	1411	2.75	***
b) 4-5 doctors		40	912	3.41	***
c) 6 or more doctors		30	332	5.45	***
Rural—Practice has branch surgery v	Surgery is 2 or more miles from home	41	500		
main surgery only		56	508	4.43	***
Non-rural—Practice has branch surgery v		16	1008		
main surgery only		17	2268	1.32	ns
Total—Practice has branch surgery v	Surgery is less than 1 mile from home	52	1508		
main surgery only		47	2776	1.88	**
Rural—Practice has branch surgery v		41	500		
main surgery only		26	508	3.88	***
Non-rural—Practice has branch surgery v		57	1008		
main surgery only		52	2268	2.13	*
Total—Single-handed practice v	Surgery is less than 1 mile from home	57	724		
a) 2-3 doctors		52	1853	2.99	ns
b) 4-5 doctors		44	1230	2.50	***
c) 6 or more doctors		40	466	3.45	***
Rural—Single-handed practice v		37	110		
a) 2-3 doctors		37	442	5.72	ns
b) 4-5 doctors		31	318	6.47	ns
c) 6 or more doctors		25	135	7.31	ns
Non-rural—Single-handed practice v		60	613		
a) 2-3 doctors		56	1411	2.68	ns
b) 4-5 doctors		49	912	2.65	***
c) 6 or more doctors		46	332	3.87	***
Total—2-3 doctors v	Surgery is less than 1 mile from home	52	1853		
a) 6-5 doctors		44	1230	2.63	**
b) 6 or more doctors		40	466	3.48	***
Rural—2-3 doctors v		37	442		
a) 4-5 doctors		31	318	6.23	ns
b) 6 or more doctors		25	135	6.34	ns
Non-rural—2-3 doctors v		56	1411		
a) 4-5 doctors		49	912	2.51	**
b) 6 or more doctors		46	332	3.80	**
Total—4-5 doctors v	Surgery is less than 1 mile from home	44	1230		
6 or more doctors		40	466	3.23	ns

Differences between other sub-groups (contd)

Sub-group	Characteristic	%	n	Standard error	Significance
Branch surgery— Single-handed v	Surgery is less than 1 mile from home	51	110		
a) 2-3 doctors		55	693	6.36	ns
b) 4-5 doctors		50	536	6.28	ns
c) 6 or more doctors		47	170	5.73	ns
No Branch surgery— Single-handed v		58	614		
a) 2-3 doctors		50	1160	2.87	**
b) 4-5 doctors		40	694	3.25	***
c) 6 or more doctors		35	296	4.33	***
Branch surgery— 2-3 doctors v	Surgery is less than 1 mile from home	55	693		
a) 4-5 doctors		50	536	4.04	ns
b) 6 or more doctors		47	170	5.57	ns
No Branch surgery— 2-3 doctors v		50	1160		
a) 4-5 doctors		40	694	3.16	**
b) 6 or more doctors		35	296	4.11	***
Distance and difficulty of journey < 1 mile: public transport v	Journey is very or fairly difficult	7	67		
a) Walking		2	1406	2.98	ns
b) going by car		2	420	3.00	ns
1-2 miles: public transport v		9	247		
a) walking		5	274	1.99	*
b) going by car		2	492	1.91	***
2-5 miles: public transport v		17	245		
a) walking		10	21	6.74	ns
b) going by car		4	475	2.59	***
Average list size and number of consultations Up to 1800 v	Has not con- sulted in last year	29	483		
a) 1801-2100		26	636	2.68	ns
b) 2101-2500		27	1162	2.33	ns
c) 2501-3000		29	1088	2.35	ns
d) 3000 or more		32	723	2.75	ns

Notes

1. For the reader who wishes to compare the complex standard error of a difference with the srs standard error, the formula for calculating $s.e._{srs}$ of the difference between two percentages, p_1 and p_2 is:

$$s.e._{srs} = \sqrt{\frac{p_1 q_1}{n_1} + \frac{p_2 q_2}{n_2}}$$

where $n_1 + n_2$ are the base sample numbers for p_1 and p_2 respectively.

2. The statistical significance of the difference between p_1 and p_2 is given by the following

$T \geq 1.96$ —difference is significant at
and < 2.58 the 0.05 level = *

$T \geq 2.58$ —difference is significant at
and < 3.29 the 0.01 level = **

$T \geq 3.29$ —difference is significant at
the 0.001 level = ***

$$\text{where } T = \frac{p_1 - p_2}{\text{s.e. of difference}}$$

The significance level is the probability of the difference being due to the chances of sampling.

Appendix C The questionnaires

As noted in Chapter 1, two questionnaires, A and B, were used. For the most part they were identical, but A, unlike B, included sections on pharmaceutical, ophthalmic and chiropody services, whilst B included an extended section on dental services. The whole of Schedule A is reproduced here but only that part of B which is not included in A, that is, questions 205-231.

Area	Address	Person

SERIAL
NUMBER

Access to Primary Health Care

2. At present, are you registered with a doctor as an NHS patient?

(a) Why are you not registered with a doctor or an NHS patient at present?

GO TO Q. 79

INTERVIEWER'S NAME

AUTHORISATION NUMBER

TIME INTERVIEW STARTED
LENGTH OF INTERVIEW

whether anyone else present at interview -

Informant interviewed alone ..	1	2	3
Someone else present part of the time ...			
Someone else present all of the time			

- SPECIFY WHO ELSE WAS PRESENT

INTERVIEWER'S ASSESSMENT OF AREA

IN WHICH INFORMANT LIVES:
Would you describe the area in which the informant lives as rural, or not?

Yes, rural

No

1. Can you tell me first of all how long have you been living at this address?

1	Less than 6 months
2	6 months but less than 1 year
3	1 year but less than 2 years
4	2 years but less than 5 years
5	5 years but less than 10 years
6	10 years but less than 20 years
7	20 years or more

SEE Q.3
ASK(a)

GO TO Q. 79

0.80 TO 0.90

YR TACT YEAR (0-1 CODES 1-2)

CO TO Q.4

No	...	A
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100		

(a) Will you be changing doctors because of this move, or do you intend to remain as a patient with your present doctor?

ASK (1)
CO TO Q.4

0 (ii) Can I just check, is that because you have moved too far away to remain as a patient with your present doctor or not?

CO TO Q.4

4. For how long have you been registered with your present doctor?

Less than 6 months	1
6 months but less than 1 year ..	2
1 year but less than 2 years ..	3
2 years but less than 3 years ..	4
3 years but less than 4 years ..	5
4 years but less than 5 years ..	6
5 years but less than 10 years ..	7
10 years but less than 20 years ..	8
20 years or more	9
Since birth/all my life	10

PROMPT AS NECESSARY

ASK(a)

GO TO Q.5

(a) Can I check, were you previously registered with any other doctor at the same practice, or not?

(i) So how long altogether have you been registered with that practice?

Less than 6 months	1
6 months but less than 1 year ..	2
1 year but less than 2 years ..	3
2 years but less than 3 years ..	4
3 years but less than 4 years ..	5
4 years but less than 5 years ..	6
5 years but less than 10 years ..	7
10 years but less than 20 years ..	8
20 years or more	9
Since birth/all my life	10

PROMPT AS NECESSARY

ASK(i)

GO TO Q.5

5. Does the doctor you are registered with at present work on his/her own, or with other doctors?

Works on own	1
Works with other doctors ..	2
DK/Can't say	3

PROMPT AS NECESSARY

ASK(a)

GO TO Q.6

(a) So how many doctors altogether work on your doctor's practice (including your own doctor)?

2-3 doctors	1
4-5 doctors	2
6 or more/SPECIFY	3
DK/Can't say	9

PROMPT AS NECESSARY

ASK(a)

GO TO Q.6

THE DOCTOR'S SURVEY

I'd like to talk now about your doctor's surgery.

6. Some doctors hold all their surgeries at the same place, but others hold surgeries at different places on different days. Does your doctor

hold all his/her surgeries at the same place	1
or does he/she hold surgeries at more than one place?	2
DK/Can't say	3

PROMPT AS NECESSARY

ASK(a)&(b)

ASK(c)

ASK(a)&(b)

(a) Since you have been registered with your present doctor, has he changed his surgery premises at all?

Yes, changed premises	1
No	2
DK/Can't say	3

PROMPT AS NECESSARY

ASK(a)&(b)

ASK(c)

ASK(a)&(b)

(b) In the last five years have you been to the surgery where your doctor works (now)?

Yes	1
No	2
DK/Can't say	3

PROMPT AS NECESSARY

ASK(a)&(b)

ASK(c)

ASK(a)&(b)

(c) In the last five years, have you been to any of the surgeries where your doctor works?

Yes	1
No	2
DK/Can't say	3

PROMPT AS NECESSARY

ASK(a)&(b)

ASK(c)

ASK(a)&(b)

(i) Is there one particular place where your doctor usually goes to see the doctor?

Yes	1
No	2
DK/Can't say	3

PROMPT AS NECESSARY

ASK(a)&(b)

ASK(c)

ASK(a)&(b)

INSTRUCTION : I'd like you to think about the place where your doctor holds a surgery which is nearest to where you live. NOW ASK Q.7A

A. Approximately how far is your doctor's (present) surgery from where you live?	1
B. Approximately how far is your doctor's (usual) surgery from where you live?	2
Less than a mile	3
1 mile but less than 2 miles	4
2 miles but less than 5 miles	5
5 miles but less than 10 miles	6
10 miles or more/SPECIFY	7
DK/Can't estimate	9

PROMPT AS NECESSARY

ASK(a)

ASK(b)

ASK(c)

ASK(a)&(b)

(a) Are you registered with a doctor miles from where you live

because there isn't a doctor nearest	1
or for some other reason/SPECIFY	2
DK/Can't estimate	9

PROMPT AS NECESSARY

ASK(a)

ASK(b)

ASK(c)

ASK(a)&(b)

IF BEEN TO THE DOCTOR'S SURGERY IN LAST 5 YEARS
(Q.6(b), CODE 1; Q.6(c), CODE 1)

DNA: ALL OTHERS.....X

GO TO Q.53

8. If you were going to the surgery from home, how would you usually get there? Would you

PROMPT

- 1 walk all the way
- 2 go by public transport
- 3 go by car
- 4 or would you go in some other way? SPECIFY

DK/Can't say 8

unable to go to surgery, housebound 9 GO TO Q.22

(a) About how much would it cost you to get there and back?

- 1 Nothing, free bus pass
- 2 Less than 10 pence
- 3 10 pence but less than 20 pence ..
- 4 20 pence but less than 30 pence ..
- 5 30 pence or more/SPECIFY
- 6 DK/Can't remember
- 7
- 8
- 9

(b) Would you say that the surgery was within reasonable walking distance for you, if there was no alternative transport available?

- 1 Yes ..
- 2 No ..
- 3 DK ...

9. Approximately how long would it take you to get to the surgery from home if you were (SPECIFY MEANS OF TRANSPORT AT Q.8)

- 1 About 5 minutes (0-7 mins)
- 2 About 10 minutes (8-12 mins)
- 3 About 15 minutes (13-17 mins) ...
- 4 About 20 minutes (18-22 mins) ...
- 5 About 25 minutes (23-25 mins) ...
- 6 More than 25 minutes/SPECIFY
- 7
- 8
- 9

DK/Can't say 9

10. Do you have any difficulties at all in getting to the surgery from home?

(a) What makes it difficult for you to get to the surgery from home?

- 1 Yes ..
- 2 No ...

ASK(a)&(b)
ASK(b)

(b) So, on the whole, would you say it is usually

- 1 very easy
- 2 fairly easy
- 3 fairly difficult ..
- 4 or very difficult? ..

IF DOCTOR WORKS FROM ONLY ONE SURGERY (Q.6, CODE 1)
I'd like to ask you now about the times when the surgery is open for you to see your doctor (or any of the doctors he works with). ASK Q.11

IF DOCTOR WORKS FROM MORE THAN ONE SURGERY (Q.6, CODE 2)
I'd like to ask you now about the times when the surgery you usually go to see your doctor is open for you to see your doctor (or any of the doctors he works with). ASK Q.11

11. Is there a doctor's surgery on a Saturday, or not?

- 1 Yes ..
- 2 No ...
- 3 DK ...

ASK(a)
ASK(b)

(a) Can I just check, is the surgery you usually go to see your doctor or urgent cases only, or is it an ordinary surgery?

- 1 Urgent cases only ...
- 2 Ordinary surgery ...
- 3 Other/SPECIFY
- 4
- 5
- 6
- 7
- 8
- 9

(b) Would you like your doctor to hold a (an ordinary) surgery on Saturdays, or do you not mind?

- 1 Would like Saturday surgery
- 2 Don't mind
- 3
- 4
- 5
- 6
- 7
- 8
- 9

12. Does your doctor (or any of the doctors he works with) hold any weekday morning surgeries?

Yes ... 1
No ... 2
DK ... 3

ASK(a)
GO TO Q.13

(a) At what time do the morning surgeries start?

- 1 Before 8.00 a.m.
2 Between 8.00 and 8.29
3 Between 8.30 and 8.59
4 Between 9.00 and 9.29
5 Between 9.30 and 9.59
6 Between 10.00 and 10.29
7 10.30 or later/SPECIFY
DK/can't say

13. Does your doctor (or any of the doctors he works with) hold any weekday surgeries that go on after 5 o'clock in the evening?

Yes ... 1
No ... 2
DK ... 3

ASK(a)
GO TO Q.14

(a) At what time do these evening surgeries end?

- 1 Between 17.00 and 17.29
2 Between 17.30 and 17.59
3 Between 18.00 and 18.29
4 Between 18.30 and 18.59
5 19.00 or later/SPECIFY
DK/can't say

14. On the whole, how convenient are the doctor's surgeries for you.

Would you say they are

- 1 very convenient
2 fairly convenient
3 fairly inconvenient
4 or very inconvenient?
5 Can't say

15. Are there any times when there isn't a doctor's surgery at present when you would particularly like there to be one?

Yes ... 1
No ... 2

ASK(a)&(b)
GO TO Q.16

(a) At what times would you like there to be a doctor's surgery?

0

(b) Why would you particularly like there to be a surgery then?

0

16. In some practices, doctors have an appointment system while in others patients must just go to the surgery and wait their turn to see the doctor. Is there an appointment system at your doctor's surgery or not?

Yes, appointment system 1
No 2
DK/No idea 3

ASK(a)
GO TO Q.21

(a) Does the doctor hold any weekday surgeries when the appointment system doesn't operate and all patients just go along and wait their turn.

Yes ... 1
No ... 2
DK ... 3

SEE Q.17

IF INFORMANTS DOCTOR WORKS ON OWN (Q.5, CODE 1),

DNM: DR. WORKS WITH OTHER DMS.

17. When you want to see your doctor at the surgery, how easy is it to get an appointment within the time you want one? On the whole, would you say it is

- 1 very easy
2 fairly easy
3 fairly difficult
4 or very difficult?
5 DK/can't say

RUNNING PROMPT

GO TO Q.21

GO TO Q.19

GO TO Q.21

IF INFORMANT'S DOCTOR WORKS WITH
OTHER DOCTORS (Q-5, CODE 2)

18. When you want to see the doctor, do you
usually prefer to have an appointment
with a particular doctor, or do you
not mind which of the doctors you see?

Prefer particular doctor 1 ASK(a)/(b)
Don't mind 2 ASK(c)

(a) When you want to see that doctor,
usually, how easy is it to
get an appointment within the time
you want one? Would you say it is
usually

very easy 1
fairly easy 2
fairly difficult 3
or very difficult? 4
DK/can't say 5

(b) If you can't get an appointment
with that doctor, how easy is it
for you to get an appointment with
any of the other doctors who work
with you? Would you say it is
usually

very easy 1 GO TO Q-21
fairly easy 2 GO TO Q-19
fairly difficult 3 GO TO Q-19
or very difficult? 4 GO TO Q-21
DK/can't say 5

(c) When you want to see a doctor at
an appointment, how easy is it to get
an appointment within the time
you want one? Would you say it is
usually

very easy 1 GO TO Q-21
fairly easy 2 GO TO Q-19
fairly difficult 3 GO TO Q-19
or very difficult 4
DK/can't say 5

19. Why is it difficult for you to get an
appointment to see the doctor,
within the time you want one?

GO TO Q-21

IF NO APPOINTMENT SYSTEM AT SURGERY,

20. Is there any other kind of arrangement
for seeing the doctor at the surgery,
or do you just go there and wait
K your turn to see him/her?

Yes, other arrangement 1 ASK(a)
No, just wait turn 2 GO TO Q-21
DK/can't say 3

(a) What kind of arrangement is there
for seeing the doctor at the surgery?

K

21. On the whole, would you prefer your
0 doctor to have

an appointment system 1
an arrangement where you go along 2 ASK(a)/(b)
and wait your turn 3
or some other kind of arrangement for
seeing him at the surgery?/SECURITY.

Don't mind 9 GO TO Q-22

(a) What do you think are the advantages
to patients of this kind of system/
0 arrangement?

(b) Do you think there are any disadvantages to
patients of this kind of system/arrangement?
0

(c) What are the disadvantages?
0

22. When was the last time you consulted your doctor, or did you consult a new doctor he works with) at the surgery (for yourself or for one of your children)?

Less than 2 weeks ago	1	GO TO Q.23
2 weeks but less than 3 months ago	2	
3 months but less than 6 months ago	3	
6 months but less than a year ago	4	
1 year but less than 2 years ago	5	
2 years but less than 5 years ago	6	
Never consulted doctor at surgery	7	GO TO Q.35
DK/Can't remember	8	
	9	

23. On that last occasion, did you go to see the doctor

because you had decided you wanted to see him	1
because he had asked you to go back and see him	2
or because you had an arrangement to see him regularly?	3
Other/SPECIFY	4

24. Can I just check on that occasion, had you made an appointment to see the doctor, or not?

Yes, had made appointment	1	ASK(a)
No	2	GO TO Q.33
DK/Can't remember	3	

(a) Was your appointment fixed on a previous visit to the doctor, or not?

Yes, fixed on previous visit	1	GO TO Q.30
No	2	ASK(1)
DK/Can't remember	3	GO TO Q.30

(1) On that occasion, did you want an appointment as soon as possible, or not?

Yes	1	SHE(1)
No	2	

IF INFORMANT'S DOCTOR WORKS WITH OTHER DOCTORS (Q-5, CODE 2) DWA: ALL OTHERS .. X

(1) Did you want an appointment with a particular doctor, or did you not mind which doctor you saw?

Wanted particular doctor	1
Didn't mind which doctor	2

25. Did you make the appointment yourself, or did someone else make it for you?

Made it myself	1	GO TO Q.26
Someone else made it	2	GO TO Q.29
Can't remember	3	

26. Did you make the appointment

RUNNING PROMPT	1	ASK(a)
by telephone	2	
by call at the surgery	3	GO TO Q.29
or in some other way/SPECIFY	4	
DK/Can't remember	9	

(a) When you telephoned the surgery to make an appointment, did you use

RUNNING PROMPT	1
your own phone	2
a neighbour's phone	3
a public call box	4
or did you phone from elsewhere? SPECIFY	5
DK/Can't remember	9

27. Did you have any difficulty in getting to a phone to make an appointment?

Yes ..	1	ASK(a)
No ..	2	GO TO Q.28
DK ..	3	

(a) Why was it difficult to get to a phone?

0

28. Did you have any difficulty in getting through to the surgery on that occasion?

Yes ..	1	ASK(a)
No ..	2	GO TO Q.29
DK ..	3	

(a) In what ways was it difficult?

0

Number always engaged

Other/SPECIFY

29. How long was it from the time when you made the appointment to the time you saw the doctor?
Was it

1 the same day GO TO Q.30
2 the next day
3 2 or 3 days later ASK(a)
4 4 or 5 days later
5 or was it some time after that? SPECIFY

DM/Can't remember

GO TO Q.30

(a) Were you satisfied with the day that you were fixed for your appointment, or would you have liked an appointment sooner?
0

GO TO Q.30

Satisfied with day

1 Would have liked appointment sooner ASK(l)
2

(i) Why would you have liked the appointment sooner?
0

30. When you went to the surgery, did you get there

1 before the time of your appointment GO TO Q.31
2 at the time arranged GO TO Q.32
3 after the time of your appointment
4 DM/Can't remember

31. When you went to the surgery, did you go in to see the doctor at the time arranged, or did you have to wait?

1 Went in on time ASK(a)
2 Had to wait GO TO Q.32
3 DM/Can't remember GO TO Q.35

(a) Did you expect to go in on time, or did you expect to have to wait?
0
Expected to go in on time
Expected to have to wait GO TO Q.35
Didn't know what to expect

32. At the surgery, how long did you have to wait after the time of your appointment, before seeing the doctor?

1 About 5 minutes (0-7 mins)
2 About 10 minutes (8-12 mins)
3 About quarter of an hour (13-17 mins)
4 About 20 minutes (18-22 mins) ASK(a)
5 About half an hour (23-27 mins)
6 About three-quarters of an hour (38-52 mins)
7 About an hour (53-60 mins)
8 More than an hour/SPECIFY

GO TO Q.35

(a) Having made an appointment, did you feel this was a reasonable time to wait to see the doctor, or not?
0

1 Yes, reasonable
2 No

SEE INSTRUCTION ABOVE(l)
ASK(b)

IF WAITED ABOUT HALF AN HOUR OR MORE (Q.32, CODES 5-8)

DM: ALL OTHERS X

(i) What made you feel this was a reasonable time to wait to see the doctor?
0

ASK(b)

(b) Did you expect to have to wait

0
RUNNING PROMPT
more time than this
less time than this
or was this about what you expected?
Didn't know what to expect

GO TO Q.35

IF DID NOT HAVE AN APPOINTMENT ON LAST OCCASION

33. When you went to the surgery on that occasion, did you get there before it was due to start, or not?

Yes, got there before
No
(a) About how long before it was due to start did you get there?

About 5 minutes before (0-7 mins)
About 10 minutes before (8-12 mins)
About 15 minutes before (13-17 mins)
About 20 minutes before (18-20 mins)
About 25 minutes before (21-25 mins)
DK/can't remember
(b) When you got there, did you go straight in to see the doctor, or did you have to wait?
(1) Did you expect to go straight in, or did you expect to have to wait?
(2) Did you expect to go straight in, or did you expect to have to wait?

1 ASK(a)
2 ASK(b)
3 GO TO Q.34A
4
5
6
1 ASK(1)
2 GO TO Q.34B
3
4
5
6
1 GO TO Q.35
2

34. A. About how long after the surgery was due to start did you wait before seeing the doctor?

About 5 minutes (0-7 mins)
About 10 minutes (8-12 mins)
About 15 minutes (13-17 mins)
About 20 minutes (18-20 mins)
About 25 minutes (21-25 mins)
About half an hour (30-37 mins)
About an hour (38-45 mins)
About an hour and a half (46-53 mins)
More than an hour/SPECIFY
DK/can't remember
(a) Did you feel this was a reasonable time to wait to see the doctor, or not?
(1) What made you feel this was a reasonable time to wait to see the doctor?

SEE INSTRUCTION
ASK(1)
ASK(b)
DNA: ALL OTHERS.....X
(1) What made you feel this was a reasonable time to wait to see the doctor?

(b) Did you expect to have to wait
0 [more time than this
[less time than this
[or what you expected?
Didn't know what to expect
RUNNING
PROMPT

I'd like to talk now about the other staff who work at your doctor's surgery (ies).

35. Is there a receptionist, or someone who acts as a receptionist, at this surgery (at any of your doctor's surgery(ies))?

Yes, more than one
No, only one
DK
(a) Is there more than one person who is, or who acts as, a receptionist at the surgery (ies)?

(b) Have you ever spoken to a receptionist either over the phone or at the surgery?

1 Yes ..
2 No ...
3 DK ...
1 Yes ..
2 No ...
3 DK ...
1 GO TO Q.36
2 GO TO Q.39
3

36. I'd like now to read out some things that people have said about the receptionists at their doctor's surgery. I'd like you to think about the receptionist(s) at your doctor's surgery and tell me whether you would agree or disagree with what has been said.

(i) she (they) tries to be as helpful as possible when you want to see the doctor
(ii) she (they) only arranges for you to see the doctor when she (they) feels it is necessary
(iii) she (they) makes you wait even though she (they) wouldn't be bothering the doctor
(iv) she (they) helps to make the surgery run more efficiently
(v) she's (they're) considerate to the patients
(vi) she (they) sometimes makes it difficult for you to see the doctor when you want to
No feelings/ No feelings/ no disagree

IF AN APPOINTMENT SYSTEM AT INFORMANT'S SURGERY
(Q.16, CODE 1)

DNA: ALL OTHERS .....X		GO TO Q.39
37. If you want an appointment to see the doctor at the surgery, does (do any of) the receptionist (s) ever ask you to say why you want to see him, or not?	Yes ... No ... DK ...	ASK(a) GO TO Q.38
(a) Is this something which happens on RUNNING PROMPT	all or most occasions or only on some occasions?	GO TO Q.38
38. On the whole, do you feel that the receptionist 0	should ask patients why they want to see the doctor at the surgery should not ask patients [or do you not mind?]	ASK(a) ASK(b) GO TO Q.39
(a) Why do you feel patients should be asked to tell the receptionist why they want to see the doctor? 0		
(b) Why do you feel patients should not be asked to tell the receptionist why they want to see the doctor? 0		GO TO Q.39

39. Are there any nurses at your doctor's surgery (at any of your doctor's surgeries) with whom you discuss the treatment of patients?
K

Yes ..	1	GO TO Q.40
No ...	2	GO TO Q.45
DK ...	3	
40. In the last year, have you been seen by a nurse at the surgery, (either for yourself or for your child) or have you been sent from at a special clinic like antenatal or baby clinics or clinics for the elderly?	Yes, been seen by nurse No, not only at special clinic DK/can't remember	SEE Q.41 GO TO Q.45
IF INFORMANT WAS CHILDREN UNDER 16, (SEE HOUSEHOLD BOX)	DNA: ALL OTHERS .....X	GO TO Q.42
41. The last time you were seen by a nurse at the surgery was it for yourself or was it for one of your children?	For self For child	1 2
42. On the last occasion when you (your child) saw the nurse, did you (he/she) see the doctor as well?	Yes, saw doctor as well No DK/can't remember	GO TO Q.43 ASK(a) 2
(a) Did you go to the surgery RUNNING PROMPT	intending to see the nurse ... intending to see the doctor ... other/SPECIFY	3 4 5

43. What did the nurse do for (your child) on that occasion?

Helped dress/undress only	1	GO TO Q.45
Dressed wound/changed dressing	2	
Gave injection/immunization	3	
Syringed ears	4	GO TO Q.44
Took blood pressure	5	
Other/SPECIFY	6	

CODE
TMT
APPLY

45. Are there any health visitors attached to your doctor's surgery (ies)?

Yes ..	1	GO TO Q.46
No ...	2	GO TO Q.51
DK ...	3	

46. In the last year, have you been seen by the health visitor at the surgery (ies) for yourself or for one of your children?

Yes	1	SEE Q.47
No	2	GO TO Q.51
Can't remember ..	3	

44. You've said that the nurse AT Q.43). For this kind of (your child) you prefer (your child) to see

the doctor	1	ASK(a)
the nurse	2	ASK(b)
or do you not mind who you (your child) see(s)?.....	3	GO TO Q.45
Other/SPECIFY	4	

RUNNING
PROMPT

(a) Why would you prefer (your child) to see the doctor for this kind of thing?

Yes, saw doctor as well	1	GO TO Q.49
No	A	ASK(a)
DK/Can't remember	2	

(a) Did you go to the surgery

0	RUNNING	intending to see the health visitor ..	3
	PROMPT	or intending to see the doctor	4
		Other/SPECIFY	5

GO TO Q.45

(b) Why would you prefer (your child) to see the nurse for this kind of thing?

IF INFORMANT HAS CHILDREN UNDER 16 (SEE HOUSEHOLD BOX)

GO TO Q.48

47. The last time you were seen by the health visitor at the surgery, did you see yourself or for one of your children?

For self	1
For child	2
For both	3

48. On the last occasion when you were seen by the health visitor, did you see the doctor as well?

Yes, saw doctor as well	1	GO TO Q.49
No	A	ASK(a)
DK/Can't remember	2	

(a) Did you go to the surgery

0	RUNNING	intending to see the health visitor ..	3
	PROMPT	or intending to see the doctor	4
		Other/SPECIFY	5

GO TO Q.45

(b) Why would you prefer (your child) to see the nurse for this kind of thing?

49. What did you (your child) see the health visitor about on that occasion?

PROBE AS FULLY AS POSSIBLE: What talked about
What advice given

50. You've said that you (your child) saw the health visitor about
(SPECIFY ACTIVITIES AND REASONS) For what reason did you prefer (your child) to see

1 the doctor
2 the health visitor
3 or do you not mind who you (your child) see(s)?
4 Other (SPECIFY)
(SELF-COMPLETION)

(a) Why would you prefer (your child) to see the doctor about this sort of thing?
0

GO TO Q.51
(SELF-COMPLETION)

(b) Why would you prefer (your child) to see the health visitor about this sort of thing?
0

GO TO Q.51
(SELF-COMPLETION)

51. Below are some alternative ways of describing doctors' surgeries. We would like you to select the one that best describes the surgery where you go to see your doctor and how you would describe it. For each pair of alternative words, please ring the appropriate number, to show how you think it is best described. So, for example, for the first pair of words, if you felt that your doctor's surgery was very welcoming, you would ring 1. If you felt that your doctor's surgery was not very welcoming, you would ring 5. If however, you felt your doctor's surgery was welcoming but not very welcoming, you would ring 2. If you felt it was neither welcoming nor unwelcoming you would ring 3, and so on.

Welcoming	.....1.....2.....3.....4.....5.....	Unwelcoming
Modern	.....1.....2.....3.....4.....5.....	Old-fashioned
Efficient	.....1.....2.....3.....4.....5.....	Inefficient
Clean	.....1.....2.....3.....4.....5.....	Dirty
Spacious	.....1.....2.....3.....4.....5.....	Cramped
Cheerful	.....1.....2.....3.....4.....5.....	Depressing
Organised	.....1.....2.....3.....4.....5.....	Disorganised
Uncrowded	.....1.....2.....3.....4.....5.....	Crowded
Friendly	.....1.....2.....3.....4.....5.....	Unfriendly
Tidy	.....1.....2.....3.....4.....5.....	Untidy
Homely	.....1.....2.....3.....4.....5.....	Impersonal
Comfortable	.....1.....2.....3.....4.....5.....	Uncomfortable

52. (a) Is there anything else you would like to say about your doctor's surgery?
0

(b) Can I just check, does your doctor hold his surgeries in a Health Centre, or not?	Yes, Health Centre ... 1	
K	No 2	
DK	DK 3	

CONTACTING THE DOCTOR OUT OF HOURS

53. In the last five years, have you ever tried to contact your present doctor (or any of the doctors he works with) outside surgery hours, either for yourself or for someone else? If so, how often, for example, late in the evening, or on a Sunday.

Yes 1 ASK(A)
No 2 GO TO Q.44
Can't remember ... 3

- (a) When was the last time you tried to contact your doctor (or any of the doctors he works with) outside surgery hours?

Less than 6 months ago 1
6 months but less than a year ago 2
1 year but less than 2 years ago 3
2 years but less than 3 years ago 4
DK/Can't remember 5

54. (a) Was it a weekday, a Saturday or a Sunday when you last tried to contact the doctor out of hours?

Weekday 1
Saturday 2
Sunday 3
Bank holiday 4

- (b) Can you remember approximately what time it was when you tried to contact the doctor?

8.00 up to 12.00 1
12.00 up to 20.00 2
20.00 up to midnight 3
Midnight up to 8.00 4
DK/Can't remember 5

55. Thinking about that last occasion when you tried to contact the doctor, what was it who needed to see him/her?

Informant 1
Spouse 2
Child (under 16) 3
Child (16 and over) . 4
Other relative/
SPECIFY 5

56. Who tried to contact the doctor? Was it

RUNNING PROMPT [you yourself 1 GO TO Q.57
or was it someone else? 2 GO TO Q.60

57. What did you do first of all to try and contact the doctor? Did you

RUNNING PROMPT [telephone the surgery 1
telephone the doctor at home 2
phone an emergency or out-of-hours number 3
or did you do something else to contact the doctor? SPECIFY 4

DK/Can't remember 9

58. When you (SPECIFY ACTIVITY AT Q.57), did you

RUNNING PROMPT [speak to your doctor (or one of the doctors he works with) 1 GO TO Q.60
speak to some other doctor 2
leave a message asking a doctor to visit 3 GO TO Q.59
or did something else happen? SPECIFY 4 ASK(A)

DK/Can't remember 9 GO TO Q.60

- (a) Can I just check, were you then able to

RUNNING PROMPT [speak to your doctor or some other doctor over the phone 1 GO TO Q.60
leave a message asking a doctor to visit 2 GO TO Q.59
or did something else happen? SPECIFY 3 GO TO Q.60

9

59. Who did you leave the message with? Was it with

- 1 someone at the surgery
2 a mechanical answering device
3 someone at an emergency or out-of-
hours number
4 or did you leave the message in some
other way/SPECIFY

DK/Can't remember 9
(a) On the whole, were you satisfied or dissatisfied with leaving a message in this way?
0 Satisfied 1 GO TO Q. 60
Dissatisfied .. 2 ASK(1)

(1) Why were you dissatisfied with this?
0

GO TO Q. 60

IF INFORMANT NEEDED DOCTOR (Q. 55, CODE 1)
IF SOMEONE ELSE NEEDED DOCTOR (Q. 55, CODES 2-5)

60. A. Did you get to see your doctor (or any of the doctors he works with) on that occasion or not?
Yes .. 1
No ... 2
ASK(a)
ASK(b)
GO TO Q. 62

(a) Did you (SPECIFIED PERSON) get to see any other doctor?
Yes .. 1
No ... 2
(b) Where did you (SPECIFIED PERSON) see the doctor? Was it
1 at home
2 at the surgery
3 or somewhere else/SPECIFY

61. How long after you first tried to contact the doctor did you see you (SPECIFIED PERSON)?

- 1 Less than 2 hours later ..
2 2-5 hours later
3 6-10 hours later
4 11-24 hours later
5 More than 24 hours later/
SPECIFY

DK/Can't remember 9 GO TO Q. 64

(a) On the whole, were you satisfied or dissatisfied with the amount of time you waited before the doctor saw you (SPECIFIED PERSON)?
0 Satisfied 1 GO TO Q. 64
Dissatisfied 2

62. As the doctor didn't see you (SPECIFIED PERSON), did he

- 1 give advice over the phone
instead
2 send someone else to see you
(SPECIFIED PERSON)
3 or make some other kind of
arrangement
4 Nothing happened

(a) Who did the doctor send to see you (SPECIFIED PERSON)?
1 Nurse GO TO Q. 63
2 Other/SPECIFY GO TO Q. 64

(b) What arrangement did the doctor make instead?

63. Would you have preferred the doctor to see you (SPECIFIED PERSON) or did you not mind that he/she
0 (SPECIFY ACTIVITY AT Q.62)?

Would have preferred to see doctor	1	ASK(a)
Did not mind	2	GO TO Q.64

(a) Why would you have preferred the doctor to see you (SPECIFIED PERSON) rather than
(SPECIFY ACTIVITY AT Q.62)?

64. Have there been any occasions in the last five years when you have seriously considered contacting your present doctor (or any of the doctors he/she works with) outside surgery hours, but decided not to?

Yes	1	ASK(a)
No	2	GO TO Q.65
Can't remember	3	

(a) The last time you considered this, what made you decide not to contact the doctor?

DAY TIME HOME VISITS

65. Have you ever asked your present doctor (or any of the doctors he/she works with) to make a daytime home visit, either for yourself or for a member of your family?

Yes	1	ASK(a)
No	2	GO TO Q.71B
Can't remember	3	

(a) When was the last time you asked your doctor to make a daytime home visit?

Less than 6 months ago	1	
6 months but less than 1 year ago ..	2	GO TO Q.66
1 year but less than 2 years ago ..	3	
2 years but less than 5 years ago ..	4	
5 years ago or more	5	GO TO Q.71A
DK/Can't remember	6	

PROMPT AS NECESSARY

66. Approximately how many times in the last year have you asked your doctor to make a daytime home visit?

Once only	1
2-3 times	2
4-5 times	3
6-10 times	4
More than 10 times ..	5

67. Have there been any occasions in the last year when you asked your doctor (or any of the doctors he works with) to make a daytime home visit, when the doctor did not come?

Yes	1	GO TO Q.68
No	2	GO TO Q.71A
Can't remember	3	

68. On the last occasion when this happened, who was it who needed to see the doctor?

Informant	1
Spouse	2
Child (under 16) ..	3
Child (16 and over)	4
Other relative/SPECIFY ..	5

69. On that occasion, did the doctor

1	GO TO Q.70
2	ASK(a)
3	ASK(b)
4	GO TO Q.71A
1	GO TO Q.70
2	GO TO Q.70

(a) Who did the doctor send to see you (SPECIFY PERSON)?

(b) What arrangement did the doctor make instead?

1	GO TO Q.70
2	ASK(a)
3	ASK(b)
4	GO TO Q.71A
1	GO TO Q.70
2	GO TO Q.70

(a) Who did the doctor send to see you (SPECIFY PERSON)?

(b) What arrangement did the doctor make instead?

70. Would you have preferred the doctor to visit you (SPECIFY PERSON) or did you not mind that he/she

0 (SPECIFY ACTIVITY AT Q.69)?

Would have preferred doctor to visit

Did not mind

(a) Why would you have preferred the doctor to visit you (SPECIFY PERSON) rather than

0 (SPECIFY ACTIVITY AT Q.69)?

1 ASK(a)
GO TO Q.71A

2

1 ASK(a)
GO TO Q.71A

2

71. IF HAS EVER ASKED DOCTOR TO MAKE A HOME VISIT (Q.65, CODE 1)
0 VISIT (Q.65, CODE 2-3)

A. On the whole, how easy do you think it would be to get your doctor (or any of the doctors he works with) to make a daytime home visit, when you feel it is necessary. Would you say it is

1	GO TO Q.72
2	GO TO Q.72
3	ASK(a)
4	ASK(a)
5	GO TO Q.72
9	GO TO Q.72

(a) What makes you think it is (would be difficult) to get your doctor to make a daytime home visit?

DK/Can't say

72. Have there been any occasions in the last year when you have seriously considered asking the doctor to make a daytime home visit, but decided not to?

(a) The last time you considered asking the doctor to make a daytime home visit, what made you decide, not to?

Yes
No
Can't remember

1 ASK(a)
GO TO Q.73

2

3

TELEPHONE CONSULTATIONS

73. In the last year, have you been given any advice over the phone from any doctor or any of the doctors he works with? Or either for yourself or for a member of your family.

(a) Approximately how many times in the last year have you been given advice over the phone by your doctor?

1 ASK(a)
2 SEE Q.77
3

Yes
No
Can't remember

Once only
2-3 times
4-5 times
More than 5 times

1
2
3
4

74. Approximately how long ago was the last time you were given advice over the phone?

1
2
3

Less than 3 months ago
3 months but less than 6 months ..
6 months but less than 1 year ago ..

1
2
3

75. On the last occasion, was the doctor giving you advice for yourself or for someone else who was ill?

1
2

For self
For someone else

76. Would you have preferred the doctor to see you (the patient) or were you satisfied with being given advice over the phone?

1 ASK(a)
2 ASK(b)

Would have preferred doctor to see patient.
Satisfied with advice over phone

1
2

(a) Why would you have preferred the doctor to see you (the patient)?

ASK(c)

(b) What made you satisfied with being given advice over the phone on that occasion?

IF INFORMANT'S DOCTOR WORKS WITH OTHER DOCTORS (Q-5, CODE 2)

I'd like to talk to you now about your doctor himself/herself. So, can I just check

77. Is the doctor you are registered with the one you think of as YOUR doctor?

(a) Is there any doctor at the practice where you are registered whom you think of as YOUR doctor?

(i) Is there a doctor at the practice with whom you have had most contact?

Yes
No
Not had contact with any

1
2
3
4
5

INSTRUCTION: I'd like you to think now about the doctor at the surgery where you are registered, who you have seen most recently. NOW ASK Q.78

78. (a) I'm going to read out some things people have said about their doctors. For each one, I'd like you to say whether or not you think it is like this or not, and how important you think this is in a doctor.

INTEVIEWER: FOR EACH OF THE STATEMENTS BELOW, ASK(a) AND (b)

(a) Do you think your doctor is like this or not?

(b) How important do you think this is in a doctor? Would you say it is very important, important, or not important?

(i) He's the kind of person you can talk to

(ii) He takes care to explain things as fully as possible

(iii) He's always willing to sit and listen to you

(iv) He's someone you could go to for help and advice

(v) He always seems very friendly

(b) Is there anything else you would like to say about your doctor?

0

I'd like to ask you now about the number of times you have consulted a doctor in the last year for yourself.

79. Can I just check, how many times in the last year have you consulted your doctor (or any of the doctors he works with) for yourself (or your family) at home or at the surgery?

80. In the last year, have you consulted any GP or family doctor privately for yourself?

(a) Approximately how many times have you consulted privately in the last year?

(b) On the last occasion, why did you choose to go to a doctor as a private patient?

(c) Did you consult that doctor under a private insurance scheme, or not?

81. In the last year, have you consulted any other GP or family doctor privately? I mean outside the hospital, but including doctors seen at work or on holiday.

(a) Approximately how many times in the last year have you consulted a (other) GP(s) or family doctor(s)?

Not at all 1
Once only 2
2-3 times 3
4-5 times 4
6-10 times 5
More than 10 times .. 6
DK/Can't say 7

Yes .. 1
No ... 2

Once only 1
2-3 times 2
4-5 times 3
6-10 times 4
More than 10 times .. 5
DK/Can't say 6

Yes .. 1
No ... 2

ASK(a)
SEE Q.82

Once only 1
2-3 times 2
4-5 times 3
6-10 times 4
More than 10 times .. 5
DK/Can't say 6

IF INFORMANT HAS CONSULTED ANY DOCTOR FOR SELF IN LAST YEAR (Qs. 79, 81, 81)

SEE Q.83

DNA: ALL OTHERSX

82. Have any of the consultations you have made over the last year been for medical problems or health problems which you have had all or most of the time?

(a) What kind of health problems have you consulted the doctor about?

TO ALL NHS REGISTERED (Q.2, CODE 1), DNA: ALL OTHERSX

83. In the last year, have there been any occasions when you have consulted a doctor (or any of the doctors he works with), then decided against it?

(a) Thinking about the last time this happened, what did you consider going to the doctor about?

PROBE TO GET FULL DETAILS OF COMPLAINT

(b) Why did you decide against going to see your doctor?

(c) What did you do instead of going to the doctor?

84. In the last year, have there been any occasions when you have taken someone in a chemist's shop for advice, instead of going to see a doctor (or any of the doctors he works with)?

Yes .. 1 ASK(a)-(c)
No ... 2 GO TO Q.85

(a) Thinking about the last time this happened, what did you ask for advice about?

PLEASE TO GET FULL DETAILS OF COMPLAINT

(b) What made you ask the chemist for advice, instead of going to a doctor (or any of the doctors he works with)?

(c) Did the chemist

CODE	RECOMMEND A MEDICINE FOR YOU TO TAKE?
ALL	1
THAT	2
APPLY	3

or did he advise you to do something else/SPECIFY

GO TO Q.85.

85. In the last year, have there been any occasions when you have gone to a chemist's shop for advice, instead of going to see your present doctor (or any of the doctors he works with)?

Yes .. 1 SEX(a)
No ... 2 GO TO Q.86

IF HAS CHILDREN (HOUSEHOLD BOX)

DNA: ALL OTHERS....X

(a) Thinking about the last time you did this, was it you who needed treatment, or was it one of your children?

Informant 1 ASK(b)
Child 2

(b) On the last occasion, what did you (your child) need treatment for?

PLEASE TO GET FULL DETAILS OF COMPLAINT

(c) What made you decide to go (to take your child) to the hospital casualty department instead of going to see your doctor?

IF REGISTERED WITH PRESENT DOCTOR'S PRACTICE
LESS THAN 10 YEARS (Q.4, CODES 1-5)

DMA: ALL OTHERS...X

86. I'd like to read out some things that people sometimes have wrong with them. For each one, I'd like you to tell me whether, if you had this, you would go to the doctor, or not?

INTERVIEWER: FOR EACH ITEM BELOW, ASK

(a) If you had would you go to the doctor, or not?

IF NOT GO TO THE DOCTOR, ASK (1) What would you do instead?

	(a) Go to doctor		(1) What would do instead		Office Use
	Yes	No	Any tablets, /relative medicines for advice	Other/Specify	
(i) had a heavy cold with a slight temperature for 4 or 5 days	1	2	1	2	1
(ii) a stomach upset which lasted for 3 or 4 days	1	2	1	2	1
(iii) frequent bad headaches for 2 or 3 weeks	1	2	1	2	1
(iv) bad pains in the chest for several days	1	2	1	2	1
(v) felt severely depressed for several weeks	1	2	1	2	1

(b) Why would you not go to the doctor if you felt severely depressed for several weeks?

0

87. If you were asked to describe your state of health over the last 12 months, would you say it had been

RUNNING
PROMPT

very good 1
good 2
fair 3
or poor 4

I'd like to ask you now about when you first registered with your present doctor's practice.

88. Thinking back to when you first registered with your present doctor's practice, why had you change doctors at the time. Was it because

0 RUNNING [you had changed your address
PROMPT [your old doctor had retired or died
or was it for some other reason/SPECIFY

89. At the time when you registered

with your present doctor, had you approached any other doctors, or someone about registering as their patient?

(a) How many other doctors did you approach at that time?

One 1
Two 2
Three or more/SPECIFY 3

(b) Why did you not register with the other doctor (any of the other doctors) you approached? Was it because

0 the doctor(s) was (were) unable to accept you as a patient 1
or because you decided not to register with him/her 2
Other/SPECIFY 3

ASK (1) GO TO Q.90

ASK (1) GO TO Q.90

ASK (1) GO TO Q.90

ASK (1) GO TO Q.90

ASK (1) GO TO Q.90

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ASK (1) GO TO Q.90

ASK (1) GO TO Q.90

ASK (1) GO TO Q.90

90. When you registered with your present doctor, what made you decide to do that practice, rather than any other?

DO NOT PROMPT	CODE ALL	Nearest, most convenient	1
THAT	ALL	Recommended by relatives, friends, neighbours	2
APPLY	ALL	Recommended by previous GP	3
	ALL	Parents'/spouse's GP	4
	ALL	Other/SPECIFY	5
		DK/Can't remember	9

91. If you were moving to another area, what would you set about finding a new doctor?

DO NOT PROMPT	1	Ask a friend/neighbor, to recommend one
	2	Ask present doctor to recommend one ..
	3	Go to nearest doctor's surgery
	4	Other/SPECIFY
	9	DK/No idea

92. If you were looking for a new doctor, would you prefer to register with a doctor who

RUNNING PROMPT	1	Practises on his own
	2	works in a practice with other doctors
	3	or would you not mind?

(a) Why would you prefer to register with a doctor who practises on his own/works in a practice with other doctors?

93. If you were changing doctors, is there anything (else) you would want to know about the practice of the doctor you are going to register there?

1	No, nothing
2	In Health Centre
3	Other/SPECIFY ..

(a) Why would you prefer to register with a doctor who practised in a Health Centre?

SEE Q.94

IF REGISTERED WITH PRESENT DOCTOR FOR 6 MONTHS OR MORE (Q.4, CODES 2-8)

GO TO Q.101

94. Have you ever seriously considered changing from your present doctor and registering with another one?

(a) Why have you considered changing doctors?

Yes ..	1
No ...	2

GO TO Q.101

(b) Are you still considering changing, or have you decided not to?

GO TO Q.101
ASK(1)

1

2

Still considering it

Have decided not to

(1) What made you decide not to change doctors?

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Section 2. District Nurses and Health Visitors

I'd like to go on and talk to you now about the district nurse(s) who visit(s) your home and other health services you may have used.

101. In the last two years, have you or a member of your family been visiting with a district nurse at the time been visited at home by a district nurse?

DO NOT INCLUDE VISITS FROM MEMBERS

102. When was the last time a district nurse came to see you or a member of your family at home?

Prompt as necessary
Less than a month ago
1 month but less than 6 months ago
6 months but less than a year ago
1 year but less than 2 years ago
2 years or more
DK/Can't remember

(a) On that last occasion, who did the nurse come to see?

Informant
Spouse
Child (under 16)
Child (16 and over)
Other relative/
SPECIFY

IF IN LAST YEAR (Q.102, CODES 1-3)

DNA: ALL OTHERS

103. Approximately how many times have you (PERSON SPECIFIED AT Q.102(a)) been visited by a district nurse in the last year?

Prompt as necessary
1-2 times
3-5 times
6-10 times
More than 10 times

IF BEEN VISITED WITHIN LAST MONTH (Q.102, CODE 1)

(a) Is the nurse visiting regularly at present, or not?

Yes, regularly
No
DK/Can't say

104. I'd like to ask you now about the last time the district nurse(s) came to visit your home. At that time, was she visiting regularly, or not?

0

Yes, regularly
No
DK/Can't say

NURSE VISITING AT PRESENT

A. Who first arranged for this nurse to come and see you (SPECIFIED PERSON) at home?

B. When she was visiting regularly, who first arranged for the nurse to come and see you (SPECIFIED PERSON) at home?

Own doctor
District nurse herself
Other/SPECIFY

NURSE VISITING AT PRESENT

A. How often is the nurse visiting you (SPECIFIED PERSON)? Is it

more than once a week
about once a week
about once every 2 weeks
or is (was) it less often than that? SPECIFY

NURSE NOT VISITING AT PRESENT

B. At that time, how often was the nurse visiting you (SPECIFIED PERSON)? Was it

more than once a week
about once a week
about once every 2 weeks
or is (was) it less often than that? SPECIFY

107. On the last occasion the district nurse came to visit you (SPECIFIED PERSON) did you know that she would be calling at some time?

Yes
No
Can't remember

(a) Had you or anyone in the family asked her to call, or not?

Yes, asked
No

(1) Who had told you that a district nurse would be calling to see you (SPECIFIED PERSON)? Was it

the nurse herself
the doctor
or someone else? SPECIFY

108. Do you know who arranged for the district nurse to call?

(a) Who arranged for her to call?

Yes ..
No ..

Doctor

Other/SPECIFY

(b) Were you expecting the doctor to call instead, or not?

Yes ..

No ..

DK ...

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ASK(2)(4)(6)
ASK(5)

IF NOT BEEN VISITED BY DISTRICT NURSE IN LAST 2 YEARS (Q.101, CODES 2-3)

111. Do you know what sorts of things district nurses do when they visit people at home?

PROBE AS FULLY AS POSSIBLE FOR SPECIFIC ACTIVITIES.

No, no idea

Yes/SPECIFY

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ASK(2)(4)(6)
ASK(5)

IF NOT BEEN VISITED BY DISTRICT NURSE IN LAST 2 YEARS (Q.101, CODES 2-3)

111. Do you know what sorts of things district nurses do when they visit people at home?

PROBE AS FULLY AS POSSIBLE FOR SPECIFIC ACTIVITIES.

No, no idea

Yes/SPECIFY

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114. On the last occasion a health visitor came, did you know that she would be calling at some time, or not?

Yes ... 1 ASK(a)
No ... 2 GO TO Q.115
DK ... 3

(a) Had you or anyone in the family asked her to call, or not?

Yes, asked 1 GO TO Q.116
No ... 2 ASK(l)

(l) Who had told you that a health visitor would be calling? Was it ...

RUNNING PROMPT
the health visitor herself ... 1 GO TO Q.116
the doctor ... 2
or someone else? / SPECIFY ... 3

115. Do you know who arranged for the health visitor to call?

Yes ... 1 ASK(a)&(b)
No ... 2 ASK(b)

(a) Who arranged for the health visitor to call?

The doctor ... 1
Other / SPECIFY 2

(b) Were you expecting the doctor to call instead, or not?

Yes ... 1
No ... 2
DK ... 3

116. On that last occasion, what did the health visitor come about?

PROBE AS FULLY AS POSSIBLE: What came about.
What talked about.
What advice given.

117. You've said that the health visitor came about (SPECIFY ACTIVITY AT Q.116). For this kind of thing, would you prefer

RUNNING PROMPT
the health visitor to come 1 ASK(a)
the doctor to come 2 ASK(b)
or do you not mind who comes? 3 GO TO Q.119

(a) Why would you prefer the health visitor to come for this kind of thing?

(b) Why would you prefer the doctor to come for this kind of thing?
GO TO Q.119

IF NOT BEEN VISITED BY HEALTH VISITOR IN LAST 2 YEARS (Q.113, COMES 2-4)

118. Do you know what sorts of things health visitors do, when they visit people at home?

K No, no idea
Yes / SPECIFY 2

PROBE: 'What sorts of things does she come about.'
'What sorts of things does she give advice about.'

119. If you wanted a health visitor to come and see you or a member of your family, what advice would you act about getting one to call?

K CODE
Ask doctor 1
Other / SPECIFY 2
That 3
Apply 9

DK / No idea 9

Section 3: Pharmacies

It'd like to talk to you now about getting prescriptions dispensed.

TO ALL NHS REGISTERED PATIENTS, DINA: Not registered....X

151. In practices in some areas, doctors supply their patients with the medicines they need, rather than writing them a prescription.

K In the practice you go to, does the doctor (or doctor/s) usually supply you with medicines or does he/she usually give you a written prescription?

Usually supplies medicines 1

Usually gives written prescription 2

152. Approximately how many times in the last year have you been given a written prescription for yourself (or any of the doctors he works with)?

Not at all 1

1-2 times 2

2-3 times 3

4-5 times 4

6-10 times 5

More than 10 6

Can't say 7

(a) In the last year, have you been given a written prescription for yourself (or any of the doctors he works with) who was living with you at the time?

Yes 1

No 2

DK 3

(b) When you last saw your doctor either at the surgery, or at home, did he give you a prescription, or not?

Yes 1

No 2

DK 3

(c) On that occasion, did you get the prescription from your doctor

at the surgery 1

at home, when the doctor visited 2

by post 3

or did someone collect it for you? 4

Other/SPECIFY 5

(d) On the last occasion your doctor gave you a written prescription, did you get it

at the surgery 1

at home, when the doctor visited 2

by post 3

or did someone collect it for you? 4

Other/SPECIFY 5

153. Did you take that prescription to a chemist's shop yourself, or did someone take it for you?

Took it myself 1

Someone took it for me 2

154. Does someone else usually take prescriptions to a chemist's for you, or do you usually take them yourself?

Someone else usually takes them 1

Usually take them myself 2

It depends/SPECIFY 3

DK/Can't say 9

IF NOT OBVIOUSLY HOUSEBOUND, DINA: Obviously housebound...X

(a) Can you tell me why you usually ask someone else to take your prescriptions to a chemist for you?

Relative 1

Friend/neighbour 2

Other/SPECIFY 3

(b) Who usually takes your prescriptions to the chemist?

Relative 1

Friend/neighbour 2

Other/SPECIFY 3

(c) On the whole, how easy is it for you to get someone else to take your prescriptions to the chemist? Would you say it is

very easy 1

fairly easy 2

fairly difficult 3

or very difficult? 4

(i) What makes it difficult to get someone else to do this for you?

0

1

2

3

4

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9

156. In the last year, have you yourself taken a prescription to a chemist's shop to be dispensed?	Yes ... No ... DK ...	1 2 3	GO TO Q.156 GO TO Q.167
157. On the last occasion, how long was it after you handed it in, before the prescription was ready?	Up to 5 minutes 6-10 minutes 11-15 minutes More than 15 minutes/SPECIFY.	1 2 3 4	GO TO Q.157 GO TO Q.157 GO TO Q.157 ASK (a)&(b)
(a) Was there any particular reason why you had to wait minutes for the prescription to be ready?	DK/can't remember No particular reason No DK/can't say	1 2 3 4	GO TO Q.157 GO TO Q.157 GO TO Q.157 GO TO Q.157
(b) Did the time you had to wait for the prescription to be ready cause any difficulties for you, or not?	Yes, difficulties No DK/can't remember	1 2 3	ASK (1) GO TO Q.157
(c) What difficulties did it cause?	0		
158. Is there a chemist's shop you usually go to to get prescriptions from your doctor dispensed?	Yes No Can't say	1 2 3	ASK (a) GO TO Q.167
(a) Is the chemist's you usually go to	0		
(b) Is that chemist's nearer to the doctor's surgery, or nearer to where you live?	Nearer surgery Nearer where live Same distance from both	1 2 3	GO TO Q.158 GO TO Q.158 GO TO Q.158
IF USUAL CHEMIST NEAR DOCTOR'S SURGERY,			
159. (a) How far is the chemist's shop you usually go to from your doctor's surgery?	Less than a mile 1 mile but less than 2 miles 2 miles but less than 3 miles 3 miles or more/SPECIFY	1 2 3 4	GO TO Q.159 GO TO Q.159 GO TO Q.159 GO TO Q.159
(b) Would you go in some other way/SPECIFY	DK/can't estimate	9	
159. If you were going to that chemist's from the surgery, how would you usually get there? Would you	walk all the way go by car use public transport or would you go in some other way/SPECIFY	1 2 3 4	ASK (a) ASK (1)
(a) Approximately how long would it take you to get to that chemist's from the doctor's surgery?	DK/can't say	9	
(b) About 5 minutes (0-7 mins) About 10 minutes (8-12 mins) About 15 minutes (13-17 mins) About 20 minutes (18-22 mins) More than 20 minutes /SPECIFY	DK/can't say	1 2 3 4 5 9	SEE (1) GO TO Q.160
IF NOT 'WALK ALL THE WAY,'	DNA: ALL OTHERS.....X		
(1) Would you say that chemist's is within reasonable walking distance for you from the surgery? If not, what is the alternative transport available?	Yes No DK	1 2 3	

160. Is the chemist's shop you usually go to the nearest one to your doctor's surgery, or not?

Yes, nearest	1
No	2
DK/Can't say	3
161. How far is that chemist's shop from where you live?	
Less than a mile	1
PROMPT AS	2
NECESSARY	3
1 mile but less than 2 miles	4
2 miles but less than 5 miles	5
5 miles or more/SPECIFY	6
DK/Can't estimate	9

162. If you had been to that chemist's shop to get your doctor's surgery, how would you usually get home from there? Would you

Running	1
PROMPT	2
go by car	3
go by public transport	4
or would you go in some other way? /SPECIFY	5
DK/Can't say	9

(a) Approximately how long would it take you to get home from that chemist's shop?

About 5 minutes (0-7 mins)	1
PROMPT AS	2
NECESSARY	3
About 10 minutes (8-12 mins)	4
About 15 minutes (13-17 mins)	5
About 20 minutes (18-20 mins)	6
More than 20 minutes/SPECIFY	7
DK/Can't say	9

163. Can I just check, is that chemist's shop the nearest one to where you live, or not?

Yes, nearest	1
No	2
DK/Can't say	3

IF USUAL CHEMIST NEAR WHERE LIVE,
164. How far is the chemist's shop you usually go to from where you live?

Less than a mile	1
PROMPT AS	2
NECESSARY	3
1 mile but less than 2 miles	4
2 miles but less than 5 miles	5
5 miles or more/SPECIFY	6
DK/Can't estimate	9

165. If you were going to that chemist's shop to get your doctor's surgery, would you usually get there? Would you

Running	1
PROMPT	2
walk all the way	3
go by car	4
go by public transport	5
or would you go in some other way? /SPECIFY	6
DK/Can't say	9

(a) Approximately how long would it take you to get to that chemist's shop from home?

About 5 minutes (0-7 mins)	1
PROMPT AS	2
NECESSARY	3
About 10 minutes (8-12 mins)	4
About 15 minutes (13-17 mins)	5
About 20 minutes (18-20 mins)	6
More than 20 minutes/SPECIFY	7
DK/Can't say	9

IF NOT 'WALK ALL THE WAY', DWA: ALL OTHERSX

(1) Would you say that chemist's shop was within reasonable walking distance for you, if there was no alternative transport available?	1
Yes	2
No	3
DK	4

166. Can I just check, is that chemist's shop the nearest one to where you live, or not?

Yes	1
No	2
DK	3

167. How far is the nearest chemist's shop from where you live? I mean a chemist's shop where you can get prescriptions dispensed?

Less than a mile	1
PROMPT AS	2
NECESSARY	3
1 mile but less than 2 miles	4
2 miles but less than 5 miles	5
5 miles or more/SPECIFY	6
DK/Can't estimate	9

GO TO Q.172

IF NOT OBVIOUSLY HOUSEBOUND, DNA: Obviously housebound...X

168. If you were going to that chemist's from home, how would you usually get there? Would you

RUNNING
PROMPT
[] walk all the way
[] use public transport
[] or would you go in some other way? /SPECIFY

DK/Can't say

(a) Approximately how long would it take you to get to that chemist's from home?

PROMPT AS
NECESSARY
[] About 5 minutes (0-7 mins)
[] About 10 minutes (8-12 mins)
[] About 15 minutes (13-17 mins)
[] About 20 minutes (18-22 mins)
[] More than 20 minutes /SPECIFY

DK/Can't say

IF NOT 'WALK ALL THE WAY' DNA: All Others

(1) Would you say that chemist's shop was within reasonable walking distance of your home? If not, was there no alternative transport available?

DK/Can't say

169. On the whole, how easy would you say it is for you to get to that chemist's shop from home? Would you say it is

RUNNING
PROMPT
[] very easy
[] fairly easy
[] neither easy nor difficult
[] or very difficult?
[] Can't say

GO TO Q.170

TO ALL WHO REGISTERED (0.2 CODE 1) DNA: Not registeredX

GO TO Q.201

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

GO TO Q.171

171. Is there a chemist's shop you know of where you could get a prescription dispensed late in the evening or on a Sunday?

Yes, evenings and/or Sundays

No

(a) If you wanted to get a prescription dispensed late in the evening or on a Sunday, what would you do to try and find a chemist's where you could get it dispensed?

Look in newspaper

Look at list in chemist's window

Ask someone at doctor's surgery

Ask relative/friend/neighbour

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

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Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

Other/SPECIFY

(c) Did you use a repeat prescription card to get your prescription, or not?

Yes

No

DK

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Section 4: Dentists

Now I'd like to ask you about going to the dentist. So, first of all, can you tell me

201. Do you have all or some of your natural teeth, or have you lost them all?

Has all/some natural teeth	1	GO TO Q.204
Has lost them all	2	GO TO Q.202

IF INFORMANT HAS LOST ALL NATURAL TEETH.

202. How long ago did you lose the last of your natural teeth?

Less than 5 years ago	1
5 years but less than 10 years ago ..	2
10 years but less than 20 years ago ..	3
20 years ago, or more	4
DK/Can't remember	5

203. About how long ago did you last go to the dentist?

Less than a year ago	1
1 year but less than 2 years ago ..	2
2 years but less than 5 years ago ..	3
5 years but less than 10 years ago ..	4
10 years but less than 20 years ago ..	5
20 years ago or more	6
DK/Can't remember	7

(a) Do you think you go to the dentist often enough, or do you think you ought to go more often?

Go often enough	1	GO TO Q.251
Ought to go more often	2	ASK(1)
DK/Can't say	3	GO TO Q.251

(1) 'Why don't you go to the dentist more often?'

GO TO Q.251

IF INFORMANT HAS SOME OR ALL NATURAL TEETH.

204. Would you say that you go to the dentist for

ROUTINE	1	GO TO Q.251
PROMPT	2	ASK(a)
or only when you are having trouble with your teeth?	3	ASK(b)
Never go	4	ASK(a)
Other/SPECIFY	5	

(a) Do you think you go to the dentist often enough, or do you think you ought to go more often than you do?

Go often enough	1	GO TO Q.251
Ought to go more often	2	ASK(1)
DK/Can't say	3	GO TO Q.251

(1) 'Why don't you go to the dentist more often?'

GO TO Q.251

(b) Why do you never go to the dentist?

0	GO TO Q.251
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Section 5: Opticians and Ophthalmic Medical Practitioners

I'd like to talk to you now about going to the opticians. So first of all, can you tell me

231. Have you ever had glasses or contact lenses prescribed for you by an optician or a doctor, apart from at school or at a hospital?
- 1 GO TO Q.232
2 ASK(a)
3
- Yes
No, OR only at school/hospital ..
DK/can't remember
- (a) Have you ever been to an optician or a doctor for a sight test, apart from at school or at a hospital?
- 1 GO TO Q.232
2 ASK(b)
3
- Yes
No, OR only at school/hospital ..
DK/can't remember
- (b) Do you think that you should go and have your eyes tested from time to time, or not?
- 1 ASK(1)
2 GO TO Q.261
3
- Yes, should go ...
No
No, no reason
- (1) Is there any reason why you haven't ever been to have your eyes tested?
- 1

GO TO Q.261

232. When was the last time you had a sight test, apart from at school or at a hospital?
- 1 Less than 2 years ago
2 2 years ago
3 3 years ago
4 4 years ago
5 5 years ago or more
DK/can't remember
- 1 GO TO Q.253
2
3
4
5 ASK(a)

- (a) Do you think you ought to have your eyes tested more often than you do, or do you think you go often enough?
- 1 Ought to go more often
2 Go often enough
3
- (1) Why don't you go to have your eyes tested more often?
- 1 ASK(1)
2 GO TO Q.261
3

GO TO Q.261

233. Last time you went, did you go

- 0
- RUNNING PROMPT
- 1 because you were due for a sight-test
2 because you were having trouble with your eyes
3 or did you go for some other reason? SPECIFY

234. Did you have your eyes tested
- RUNNING PROMPT
- 1 by an optician
2 by your own doctor
3 or by another doctor? ASK(a)
4 Other/SPECIFY
5 GO TO Q.255

- (a) Is that doctor
- RUNNING PROMPT
- 1 a GP or family doctor
2 or is he a doctor who specialises in examining eyes?
3
4
5

235. (a) On that last occasion, where did you go to have a sight test? Was it

- RUNNING PROMPT
- 1 an optician's practice
2 a medical eye centre
3 a doctor's surgery
4 or somewhere else? SPECIFY
5

- (b) Was the place you went to last time
- 0
- RUNNING PROMPT
- 1 near where you lived
2 near where you worked
3 near both
4 or not near either of these?
5
- (1) Was it nearer where you lived or where you worked?
- 0
- 1 Nearer where lived
2 Nearer where worked
3 Same distance from both
4
5
6

IF PLACE NEAR WHERE LIVED

256. A. Approximately how far was the place you went to last time from where you lived?

- Less than a mile 1
1 mile but less than 2 miles 2
2 miles but less than 5 miles 3
5 miles but less than 10 miles 4
10 miles but less than 20 miles 5
20 miles or more/SPECIFY 6
DK/Can't estimate 9

257. Had you ever been to that optician's practice (PLACE SPECIFIED AT Q.255) before, to have your eyes tested?

Yes .. 1
No ... 2

OO TO Q.258
OO TO Q.259

IF HAD BEEN THERE BEFORE,

258. (a) For how many years have you been going there?

- Less than 2 years 1
2 years but less than 5 years 2
5 years but less than 10 years 3
10 years or more 4
DK/Can't remember 5

(b) Does the optician send you a reminder when you are due to go for a sight-test, or not?

- Yes, reminder .. 1
No 2
Other/SPECIFY .. 3
DK/Can't say ... 9

(c) When you first went there, what was the optician's practice (PLACE SPECIFIED AT Q.255) to have your eyes tested?

OO TO Q.260

IF NOT BEEN THERE BEFORE,

259. (a) What made you choose to go to that optician's practice (PLACE SPECIFIED AT Q.255) to have your eyes tested?

0

(b) Had you ever been to an optician or a doctor for a sight-test before that last occasion?

Yes .. 1
No ... 2

OO TO Q.260
OO TO Q.261

260. You said you had your last sight-test how long before that had you previously had a sight-test?

- within 2 years before 1
2 years but less than 5 years before 2
5 years but less than 10 years before 3
10 years before or more 4
DK/Can't remember 5

TO ALL INFORMANTS,

261. Have you, or any member of your family who was living with you at the time, ever been given a sight-test by an optician or doctor at home?

- Yes .. 1
No ... 2
DK ... 3

ASK(a)

GO TO Q.267

(a) Thinking about the last time, who came to give the sight-test, was it

- an optician 1
your own doctor 2
or another doctor A
Other/SPECIFY 3

(i) Can I check, is that doctor

- RUNNING 4
a GP or family doctor
or is he a doctor who
specialises in examining eyes? 5

262. Who did the optician (doctor) come to see?

Informant
Other/SPECIFY

1 GO TO Q.263A
2 GO TO Q.263B

IF OPTICIAN (DOCTOR) CAME TO SEE INFORMANT

263. A. How long ago was the last time you had a sight-test at home?

B. How long ago was the last time(PERSON SPECIFIED AT Q.262) had a sight-test at home?

Less than a year ago 1
1 year but less than 2 years ago 2
2 years but less than 5 years ago 3
5 years ago or more 4
DK/Can't remember 5

IF OPTICIAN (DOCTOR) CAME TO SEE INFORMANT

264. A. How did you first find out that it was possible to arrange to have a sight-test at home?

B. How did(PERSON SPECIFIED AT Q.262) first find out that it was possible to arrange to have a sight test at home?

1
2
3
4
5

IF INFORMANT ARRANGED IT

266. A. Did you have any difficulty in arranging an optician (doctor) who was willing to give a sight test at home?

0

(a) What sort of difficulties did you (PERSON WHO ARRANGED IT) have?

0

GO TO Q.281

267. Have you ever tried to arrange for a sight-test at home, either for yourself or for a member of your family?

(a) What did you do to try and arrange to have a sight-test at home?

(b) Why were you unable to arrange one?

0

265. Thinking about that last occasion, who arranged for the optician (doctor) to call?

Informant arranged it
Someone else arranged it
/SPECIFY..

1 GO TO Q.266A
2 GO TO Q.266B

IF SOMEONE ELSE ARRANGED IT

B. Did(PERSON SPECIFIED AT Q.265) have any difficulty in finding an optician (doctor) who was willing to give a sight-test at home?

Yes ... 1
No ... 2
DK ... 3

ASK(a)

1 GO TO Q.281

GO TO Q.281

Yes ... 1
No ... 2

ASK(a)(b)
GO TO Q.268

GO TO Q.281

268. Did you know that, in some circumstances, it is possible to arrange to have a sight-test at home?

K optician to give a sight-test at home?

Yes, knew it was possible ... 1
No, didn't know 2

GO TO Q.281

Section 6: Chiropractic

281. Have you had any chiropractic treatment in the last two years?

Yes 1 GO TO Q.282
No 2 GO TO Q.301
Can't remember 3

282. Do you have chiropractic treatment

1 regularly
2 occasionally
3 or only when your feet cause you particular trouble
4 Other/SPECIFY

RUNNING PROMPT

283. (a) When did you last have some chiropractic treatment?

1 Less than 3 months ago
2 3 months but less than 6 months ago
3 6 months but less than a year ago
4 1 year but less than 2 years ago ...

(b) What treatment did you have done last time?

1 Nails cut/trimmed
2 Corns removed/treated
3 Other/SPECIFY

(c) Who gave you the treatment? Was it

1 a chiropractor
2 a nurse
3 or someone else/SPECIFY

RUNNING PROMPT

284. On that last occasion, where did you have the treatment done? Was it

RUNNING PROMPT
1 at a chiropractor's surgery ASK(a)
2 at a health centre ASK(b)
3 at your home ASK(a)
4 or was it somewhere else/SPECIFY ..

(a) Is this where you usually go for chiropractic treatment?

Yes 1
No 2
No usual place 3
Never had treatment before .. 4

(i) Where do you usually go for chiropractic treatment?

1 A chiropractor's surgery
2 A health centre
3 On home
4 Somewhere else/SPECIFY
9 No usual place

(b) Do you usually have chiropractic treatment at home, at not?

Yes 1
No 2
No usual place 3
Never had treatment before .. 4

(i) Where do you usually go for chiropractic treatment?

1 A chiropractor's surgery
2 A health centre
3 On home
4 Somewhere else/SPECIFY
9 No usual place

IF HAS USUAL PLACE FOR TREATMENT

285. A. Approximately how far is the place you went to for treatment, from where you live?

1 Less than a mile
2 1 mile but less than 2 miles
3 2 miles but less than 5 miles
4 5 miles or more/SPECIFY
9 DK/Can't estimate

IF NO USUAL PLACE FOR TREATMENT

B. Approximately how far is the place you went to for treatment, from where you live?

1 Less than a mile
2 1 mile but less than 2 miles
3 2 miles but less than 5 miles
4 5 miles or more/SPECIFY
9 DK/Can't estimate

289. How did you set about finding a chiropodist?

286. When you went there last time, how did you get there? Did you	GO TO Q.287	1	walk all the way	1	
RUNNING	ASK(a)	2	go by public transport	2	
FRONT		3	go by car	3	
or go in some other way?/ SPECIFY	GO TO Q.287	4		4	
		9	DK/can't remember	9	
(a) How much did it cost you to get there and back?		1	Nothing - free bus pass	1	
		2	Less than 10 pence	2	
		3	10 pence but less than 20 pence ..	3	
		4	20 pence but less than 30 pence ..	4	
		5	30 pence or more/SPECIFY	5	
		9	DK/can't remember	9	
287. Did you have your last chiropody treatment done on NHS or did you have it done privately?	ASK(a)	1	On NHS	1	
	ASK(b)	2	Private	2	
	ASK(c)	3	Other/SPECIFY	3	
		9	DK/can't say	9	
(a) Have you had any private chiropody treatment in the last two years?	ASK(c)	1	Yes ..	1	
	GO TO Q.288	2	No	2	
		3	DK	3	
(b) Have you had any NHS chiropody treatment in the last two years?	ASK(c)	1	Yes ..	1	
	GO TO Q.288	2	No	2	
		3	DK	3	
(c) Do you usually have your chiropody treatment done privately?		1	Usually NHS	1	
		2	Usually privately	2	
		3	Other/SPECIFY	3	
		9	DK/can't say	9	
288. When you first started having chiropody treatment, did you yourself decide you needed it or did someone else suggest it to you?	GO TO Q.289	1	Decided myself	1	
	GO TO Q.290	2	Someone else suggested ..	2	

GO TO Q.301

Classification

301. (a) Present or last occupation of informant.

(b) Is/was informant

(c) Is/was informant

(d) Number employed in establishment

(e) Industry

1 employee
 2 self-employed
 3 manager
 4 foreman
 5 other employee
 6 none
 7 1-24
 8 25+

IF INFORMANT NOT WORKING AT PRESENT, DINA: ALL OTHERS...X

(f) Number of years since last employed

SPECIFY NO. OF YEARS

IF INFORMANT IS HOH, GO TO Q.303. ALL OTHERS, ASK Q.302

302. (a) Present or last occupation of HOH.

(b) Is/was HOH

(c) Is/was HOH

(d) Number employed in establishment

(e) Industry

1 employee
 2 self-employed
 3 manager
 4 foreman
 5 other employee
 6 none
 7 1-24
 8 25+

IF HOH NOT WORKING AT PRESENT, DINA: ALL OTHERS...X

(f) Number of years since last employed.

SPECIFY NO. OF YEARS

(a)

303. Age at which informant completed continuous full-time education.

Under 14 1
 14 years 2
 15 years 3
 16 years 4
 17 years 5
 18 years 6
 19 years and over 7
 No full-time education 8
 No full-time education 9
 Other/SPECIFY 10

304. Type of accommodation

House 1
 Self-contained flat/maisonette 2
 Rooms/bedsitter 3
 Other/SPECIFY 4

305. Doss informant/HOH

Own accommodation 1
 Rent it privately 2
 Rent from Local Authority/New Tenancy Corporation 3
 Other/SPECIFY 4

IN INFORMANT HAS MADE NO MENTION OF BEING HOUSEBOUND

DINA: HOUSEBOUND

..... X

306. Can I ask, do you have any difficulties at all in getting out and about on your own?

(a) Can I just check, can you get out and about at all?

(b) Can you get out and about on your own, or do you only go out if someone is with you?

Can get out on own 1

Only if someone with me 2

(1) Can you usually get someone to go with you when you want to go out?

Yes ... 1

No 2

(b)

IF HOUSEBOUND,

307. You said that you can't get out of the house. Can you get about the house on your own, or not?

Yes ... 1

No 2

308. Can I just check, do you have your own telephone, or not?

(a) If you were at home, and wanted to use a telephone, would you usually

RUNNING [go out and use a public call box
 PROMPT [use a neighbour's phone
 or would you phone from somewhere else/SPECIFY 3

GO TO Q.309
 ASK(c)

1 Yes ...
 2 No

309. Does any member of your household own a car or a van?

IF NOT HOUSEBOUND,

(a) Do you ever drive the car yourself, or not?

DNA: HOUSEBOUND.....X

SEE(a)
 GO TO Q.310

1 Yes ...
 2 No

310. Is there anything else that you would like to say about the health services we have been talking about?

1 Yes ...
 2 No

TIME INTERVIEW COMPLETED

INTERVIEWER: NOW RECORD DOCTOR'S NAME AND ADDRESS ON FOLLOWING PAGE.

(c)

INTERVIEWER: INTRODUCE AS BRIEFO

1. NAME OF DOCTOR WITH WHOM INFORMANT IS REGISTRED (Please include surname and initials, if known):

2. ADDRESS OF DOCTOR'S SURGERY:

3. INTERVIEWER: Please check, if possible, the information given above, if address is incorrect, record correct address in the box below.

IF INFORMANT NOT WILLING TO GIVE EITHER NAME OR ADDRESS OF DOCTOR, PLEASE RECORD REASONS BELOW.

Social Survey Division;
 Office of Population Censuses
 and Surveys;
 St. Catherine's House,
 Kingsway, London W.C.2.

(d)

SERIAL

Area	Address		Person

Access to Primary Health Care

INTERVIEWER'S NAME
AUTHORISATION NUMBER

TIME INTERVIEW STARTED
LENGTH OF INTERVIEW

Whether anyone else present at interview--

1	Informant interviewed alone ..
2	Someone else present part of the time ...
3	Someone else present all of the time

SPECIFY WHO ELSE WAS PRESENT

INTERVIEWER'S ASSESSMENT OF AREA
IN WHICH INFORMANT LIVES:
Would you describe the area in
which the informant lives as
rural, or not?

Yes, rural	1
No	2

<p>IF IN MIDDLE OF COURSE OF TREATMENT:</p> <p>209. A. Thinking about your present course of treatment (visit) what made you go to the dentist in the first place? Was it</p> <p>Because you were due for a check-up because you were having trouble with your teeth (dentures) or was it for some other reason/SPECIFY</p>		<p>IF NOT HAVING TREATMENT AT PRESENT:</p> <p>B. Thinking about your last course of treatment (visit) what made you go to the dentist in the first place. Was it</p>		<p>IF HAD ALL TREATMENT DONE ON NNS, Did the dentist recommend that you have any treatment done privately, or not?</p> <p>(a) What treatment did the dentist recommend that you have done privately?</p> <p>Crown Bridge Denture fitting Denture repairing Other/SPECIFY</p>		<p>ASK(a)&(b) GO TO Q.215</p>	
<p>RUNNING PROMPT</p>		<p>RUNNING PROMPT</p>		<p>Yes ... No</p>		<p>1 2</p>	
<p>IF IN MIDDLE OF COURSE OF TREATMENT:</p> <p>210. A. Thinking about your present course of treatment, what exactly have you had done, so far?</p> <p>HAND CODE ALL THAT APPLY Bridge Denture fitting Denture repairing Other/SPECIFY</p>		<p>IF NOT HAVING TREATMENT AT PRESENT:</p> <p>B. Thinking about your last course of treatment (visit) what exactly did you have done?</p> <p>Examination/check-up X-ray Fillings Clean/scals/polish Crown Bridge Denture fitting Denture repairing Other/SPECIFY</p>		<p>all of this treatment done on the NNS some of this treatment done on the NNS or none of this treatment done on the NNS</p> <p>(1) Did you have any difficulty in getting this treatment done on the NNS?</p> <p>Yes ... No</p>		<p>ASK(1) GO TO Q.215</p>	
<p>RUNNING PROMPT</p>		<p>RUNNING PROMPT</p>		<p>1 2</p>		<p>1 2</p>	
<p>IF HAD SOME TREATMENT DONE PRIVATELY, have done privately?</p> <p>Examination/check-up X-ray Fillings Clean/scals/polish Crown Bridge Denture fitting Denture repairing Other/SPECIFY</p>		<p>What part of the treatment did you have done privately?</p> <p>HAND CODE ALL THAT APPLY Bridge Denture fitting Denture repairing Other/SPECIFY</p>		<p>DK/Can't remember</p>		<p>20</p>	
<p>IF HAD ALL OR SOME TREATMENT DONE PRIVATELY, did you prefer to have this treatment done privately or did you prefer to have it done on the NNS?</p> <p>0</p>		<p>IF HAD ALL OR SOME TREATMENT DONE PRIVATELY, did you prefer to have this treatment done privately or did you prefer to have it done on the NNS?</p> <p>0</p>		<p>Wanted it done privately Would have preferred NNS</p> <p>(a) Did you ask the dentist if he would do this treatment on the NNS, or not?</p> <p>Yes, asked No</p> <p>(b) Were you given any reasons for not being able to have the treatment done on the NNS, or not?</p> <p>(1) What reasons were you given?</p> <p>0</p>		<p>GO TO Q.215 ASK(a)</p>	
<p>INTERVIEWER INSTRUCTION: PLEASE CHECK AND RECORD BELOW:</p> <p>(a) Amount paid for treatment</p>		<p>INTERVIEWER INSTRUCTION: PLEASE CHECK AND RECORD BELOW:</p> <p>(b) Does informant think treatment was NNS or private?</p>		<p>SEE INSTRUCTION BELOW</p>		<p>SEE Q.215</p>	
<p>1 2 3</p>		<p>1 2 3</p>		<p>1 2 3</p>		<p>1 2 3</p>	

IF INFORMANT HAS BEEN TO DENTIST IN LAST 5 YEARS,
(Q.203, CODES 1-4; Q.205, CODES 1-4)

DNA: ALL OTHERS.....X

IF IN MIDDLE OF COURSE OF TREATMENT

215. A. Thinking about the dental practice you have been going to for your present course of treatment, is this the first time you have been treated by a dentist at that practice, rather than have been there before?

First time had been there 1
Had been there before 2

216. For approximately how many years has the dentist you are now going to that dental practice?

Less than a year 1
1 year but less than 2 years 2
2 years but less than 5 years 3
5 years or more 4
DK/can't remember 5

IF HAD BEEN TO THAT DENTAL PRACTICE BEFORE

217. A. When you first went there, what made you choose that dental practice, rather than any other?

IF HAD NOT BEEN TO THAT DENTAL PRACTICE BEFORE

B. What made you choose to go to that dental practice, rather than any other?

OO TO Q.224

IF NOT HAVING TREATMENT AT PRESENT

B. Thinking about the dental practice you went to for your last course of treatment, what made you choose that the first time you had been treated by a dentist at that practice, rather than have been there before?

First time had been there 1
Had been there before 2

218. Does your dentist usually send you a reminder, when you are due for a check-up, or not?

Yes, sends reminder 1
No 2
Other/SPECIFY 3

DK/can't say 9

at the end of your last course of treatment 1
when the dentist sends you a reminder 2
or when you feel it's time to go again? 3

Other/SPECIFY 4

Do you usually make the appointment for your next check-up

at the end of your last course of treatment 1
or when you feel it's time to go again 3
Other/SPECIFY 4

Do you usually make the appointment for your next check-up

near where you live(d) 1
near where you work(ed) 2
near both 3
or not near either of these? 4

Is (was) the dentist nearer where you live(d) or nearer where you work(ed)

Nearer where live(d) 1
Nearer where work(ed) 2
Same distance from both 3

Do you usually make the appointment for your next check-up

at the end of your last course of treatment 1
or when you feel it's time to go again 3
Other/SPECIFY 4

Do you usually make the appointment for your next check-up

near where you live(d) 1
near where you work(ed) 2
near both 3
or not near either of these? 4

Is (was) the dentist nearer where you live(d) or nearer where you work(ed)

Nearer where live(d) 1
Nearer where work(ed) 2
Same distance from both 3

Do you usually make the appointment for your next check-up

at the end of your last course of treatment 1
or when you feel it's time to go again 3
Other/SPECIFY 4

Do you usually make the appointment for your next check-up

near where you live(d) 1
near where you work(ed) 2
near both 3
or not near either of these? 4

Is (was) the dentist nearer where you live(d) or nearer where you work(ed)

Nearer where live(d) 1
Nearer where work(ed) 2
Same distance from both 3

IF DENTIST NEAR WHERE
LIVE(D)

exactly how far is
entist from where
1?

B. Approximately how far is (was) the dentist from where you work(ed)?

Less than a mile
1 mile but less than 2 miles
2 miles but less than 5 miles
5 miles but less than 10 miles
10 miles but less than 20 miles
20 miles or more/SPECIFY

8 there a
here you

i) Why did you choose to travel miles to a dentist, rather than going to one nearer where you lived/worked?

	1	SEE Q.223
	2	ASK(a)
Yes ...		
No		

--	--

0.223

ALL OTHERS. ASK 0.223

ASK(2)

Wanted it done
Would have no

(c) Were you given any reasons for not being able to have the treatment done on the NHS, or not?

ASK(a)

225. On that occasion, what was the matter?

226. How soon after the trouble started did you try to see a dentist?	Same day 1 Next day 2 2-3 days later 3 4-6 days later 4 1 week later, or more 5 DK/Can't remember 6	
227. Was it a weekday, a Saturday or a Sunday when you tried to see a dentist for treatment?	Weekday 1 Saturday 2 Sunday 3 Bank Holiday 4	
(a) What time was it when you tried to see a dentist?	9.01 - 12.00 1 12.01 - 18.00 2 18.01 - 20.00 3 20.01 - 9.00 4 DK/Can't remember 5	
228. Which dentist did you try to see? Was it	RUNNING PROMPT [an ordinary dental surgeon 1 or a dentist at a hospital? 2 Yes 1 No 2	ASK(a) GO TO Q.229
229. Did you eventually succeed in getting the treatment done by that dentist.	Yes ... 1 No ... 2	ASK(a) GO TO Q.230
(a) How long after you first tried, did you succeed in getting the treatment done?	The same day 1 2-3 next day 2 2-3 days later 3 4-5 days later 4 More than 5 days later 5 DK/Can't remember 6	ASK(b) GO TO Q.301
(b) How satisfied were you with the time you waited to get the treatment done? Would you say 0 you were	very satisfied 1 fairly satisfied 2 fairly dissatisfied 3 or very dissatisfied? 4	GO TO Q.301

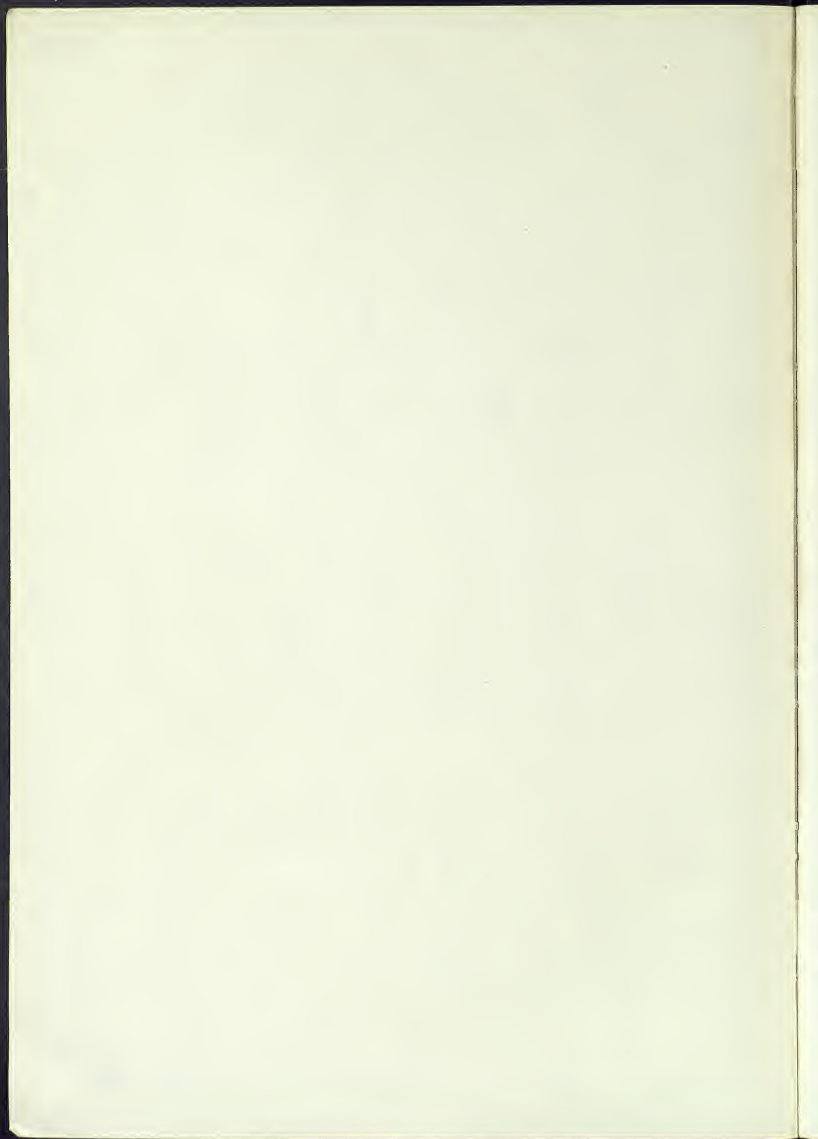
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230. Why were you unable to see that dentist?

0

231. Did you do anything else at the time to try to get the necessary treatment done, or did you just wait to see the dentist in normal surgery hours?	Yes, did something else 1 No, just waited 2	ASK(a)(b) ASK(b)
(a) What else did you do?		
(b) So, how long after you first tried did you succeed in getting the necessary treatment done?	The same day 1 The next day 2 2-3 days later 3 4-5 days later 4 More than 5 days later 5 DK/Can't remember 6	ASK(c) GO TO Q.301
(c) How satisfied were you with the time you waited to get the treatment done? Would you say 0 you were	very satisfied 1 fairly satisfied 2 fairly dissatisfied 3 or very dissatisfied? 4	GO TO Q.301

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OFFICE OF POPULATION CENSUSES AND SURVEYS
SOCIAL SURVEY DIVISION

Adult dental health

Volume 1

England and Wales

1968-1978

A survey conducted by the Social Survey Division of OPCS in collaboration with the Department of Dental Health, University of Birmingham Dental School for the United Kingdom health departments

by

J E Todd and A M Walker

This first volume of a two-part report presents data about the changes in aspects of adult dental health that have taken place in England and Wales over the ten-year period. The survey covered the extent of total tooth loss and partial denture wearing; people with natural teeth; the condition of individual teeth; and changes in dental attendance patterns and attitudes to treatment.

The report also covers the background to the survey, including a commentary on the methodology, sampling, interviewing and the response.

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